DR ANDREW TEICHTAHL (MBBS (Hons), B.Physio (Hons), FRACP, PhD)
RHEUMATOLOGIST

Confidential Patient Registration Form

Surname_____Title: Mr. Mrs. Miss. Ms. Dr. Rev _____

Given Name_____ (name on Medicare card)

Date of Birth ___/___/___

Home address _____

Suburb _____

State _____ Postcode _____

Home phone _____ Business phone_____

Mobile_____

Email _____

Medicare No __ __ __ __ __ __ __ __ __ __ Ref No __ Expiry __/__

Private Health Fund Yes/No Name_____

Membership number_____

Are you on a full pension or Health Care Card? Yes/No

Number_____ Expiry _____

Next of Kin contact name_____

Next of kin contact phone _____

Relationship to patient _____

Referring Doctor _____

Doctor Contact details _____

Usual GP details (if different to above) _____

Signed_____ Date _____

Dr Andrew Teichtahl

MBBS (Hons), B.Physio (Hons), FRACP, PhD

All bookings and correspondence:
46 Heatherton Road, Endeavour Hills, 3802
Phone: 9700 7666
Fax: 9700 5952

Arthritis & Rheumatology Centre

Consulting at

Knox Private Hospital (Mon)
Wellness on Wellington (Tue)
Heatherton Road Specialist Centre (Wed)
Blackburn Specialist Centre (Tues/Sat)
Manningham Consulting Suites (Thurs)

Privacy Statement

Arthritis & Rheumatology Centre collects personal information from you for the primary purpose of providing quality healthcare. We require your consent to collect personal information about you. Please read this information carefully, and sign where indicated below.

We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. This means we will use the information you provide to this practice in the following ways:

- Administrative purposes in running our medical practice
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements
- Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice
- This may occur through referral to other doctors or for medical tests and in the reports or results returned to us following the referrals.

I have read the information above and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling patient information. I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to me.

I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld, I understand I will be given an explanation in these circumstances. I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.

I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure that I notify this practice of.

Signed _____ Date: _____

Full name of patient _____