Patient Registration Form

Fax: (02) 9399 8981 . Email: referrals@entsydney.com

Preferred Doctor

☐ **Dr Ian Jacobson** ☐ **Dr Greg Lvoff** ☐ **Dr Tom Kertesz** ☐ First available ☐ Audiologist/ Hearing Aid Assesment

Personal Details

Title	Surname	Given Name(s)
Address	Suburb	Postcode
Date of Birth	Home Phone	Mobile
Work Phone	Email Address	

Memberships - Medicare

Medicare No.	Medicare Reference No.	Expiry Month	Expiry Year

Memberships - Private Health Fund

Name of Private Health Fund	Private Health Fund Medicare No.

Presenting Problems

Presenting Problem. What is the reason for your visit?

Patient Occupation	Referring Doctor/Dentist

Patient under 17 years (For BILLING purposes please provide the following information).

Patient 1 - Full Name	Date of Birth	Medicare Reference No.
Patient 2 - Full Name	Date of Birth	Medicare Reference No.

Patient History - Q&A (Please answer the following questions by selecting YES or NO).

1. Have you had any past ENT Surgical procedures?

○ Yes ○ No

If Yes, please list past surgeries

2. Do you take any regular medications?

○ Yes ○ No

If Yes, please list your medications

3. Are you allergic to any medicines?

○ Yes ○ No

If Yes, please give details

4. Have you had any investigations regarding your presentation

○ Yes ○ No

Please list and indicate where test was undertaken

☐ **Consent for internal use**. All above information is for our records only and is strictly private and confidential.

Patient Signature **Signature** Day/Month/Year **Date**

Sydney Adult & Children's Ear Nose Throat Centre
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