# NEW Patient Registration Form

LEON LAI
Professor of Neurosurgery

## PATIENT INFORMATION

TITLE: FIRST NAME: (Official first name e.g. on birth certificate)

MIDDLE NAME: LAST NAME:

D.O.B: / / SEX ASSIGNED AT BIRTH:

PREFERRED NAME: (Name by which you prefer to be addressed)

PRONOUNS:

## FOR PATIENTS UNDER THE AGE OF 18

GUARDIAN/PARENT FIRST NAME: GUARDIAN/PARENT SURNAME:

GUARDIAN/PARENT D.O.B: / / GUARDIAN/PARENT CONTACT NUMBER:

GUARDIAN/PARENT MEDICARE NO: REF NO: EXPIRY: / /

GUARDIAN/PARENT EMAIL ADDRESS:

## RESIDENTIAL ADDRESS

STREET:

SUBURB: POSTCODE:

## POSTAL ADDRESS

☐ SAME AS RESIDENTIAL ADDRESS

STREET:

SUBURB: POSTCODE:

## CONTACT DETAILS

EMAIL ADDRESS:

USUAL HOME PHONE: USUAL WORK PHONE:

USUAL MOBILE PHONE: MOBILE FOR TEXTING? ☐ Y ☐ N

## HEALTH FUNDS & INSURANCE

MEDICARE NO: REF NO: EXPIRY: / /

PRIVATE HEALTH FUND NAME: MEMBERSHIP NO:

LEON LAI
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MBBS FRACS PhD MBA

P 03 9594 2464 E admin@drleonlai.com www.drleonlai.com

Suite E, Jessie McPherson Private Consulting Suites
246 Clayton Rd Clayton VIC 3168 Provider No. 5309829J ABN 29 650 002 583

## CONCESSION CARDS, IF APPLICABLE

DVA/VETERAN NO: DVA/VETERAN CARD TYPE: (gold, white, orange) EXPIRY: / /

HEALTH CARE NO: EXPIRY: / /

PENSION NO: EXPIRY: / /

## REFERRER / PRACTITIONER DETAILS:

REFERRING DOCTOR'S NAME: PRACTICE NAME:

PRACTICE ADDRESS: PHONE:

GENERAL PRACTITIONER'S NAME: PRACTICE NAME:

PRACTICE ADDRESS: PHONE:

## EMERGENCY CONTACT

FIRST NAME: LAST NAME

RELATIONSHIP: CONTACT NUMBER:

## Fee Policy

There is a consultation fee and this is payable on the day of consultation. Failure to attend/ missed appointments, without prior contact to the office will incur a fee. By signing this form, you are agreeing to the fee policy. Surgical fees are discussed only if surgeon has recommended a procedure.

## Privacy Statement

Professor Leon Lai complies with the Health Records Act 2001 (Vic) and the Privacy Act 1988 (Cth) in collecting, storing, and sharing your personal and health information. Your information is used to provide medical care, manage appointments, communicate with other healthcare providers, and meet legal and billing obligations. It may be shared with your general practitioner, hospitals, radiologists, or other specialists directly involved in your care. All information is securely stored and handled in accordance with the Health Privacy Principles and Australian Privacy Principles. You may request access to or correction of your records at any time. For more information, please contact our practice or visit www.hcc.vic.gov.au.

## Patient Consent

I consent to the collection, use, and disclosure of my personal and health information by the practice of Professor Leon Lai for the purposes described above, in accordance with the Health Records Act 2001 (Vic) and the Privacy Act 1988 (Cth).

PATIENT'S SIGNATURE: DATE:

PATIENT'S NAME (print):

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