METRO ENT

Dr Ryan De Freitas
MBBS (Hons), BMedSci, MRCS, DOHNS, FRACS

Patient Registration Form

Patient Details

First Name ..... Last Name .....

DOB ... / ... / ... Occupation .....

Gender ☐ Woman ☐ Man ☐ Non-Binary ☐ Prefer not to say ☐ Specify .....

Address .....

Suburb ..... Postcode ..... State .....

Phone ..... Mobile .....

Email .....

Please provide your mobile number as we will send SMS messages regarding your referral and appointments.

Have you seen Dr Ryan De Freitas before? ☐ Yes ☐ No

If so, at which location did you see him? ☐ Brighton ☐ Mildura

Do you identify as Aboriginal or Torres Strait Islander (ATSI)? ☐ Yes ☐ No

Medicare / Pension Information

Medicare Number ..... Reference Number ..... Expiry ... / ...

Pension Card Number ..... Expiry ... / ...

Private Health Insurance ☐ Yes ☐ No (skip to next section)

Fund Name ..... Membership Number .....

Hospital Cover? ☐ Yes ☐ No Time with health fund less than 12 months? ☐ Yes ☐ No

Emergency Contact / Next of Kin / Caregiver / Account Holder

First Name ..... Last Name .....

DOB ... / ... / ... Relationship .....

Phone .....

METRO ENT
2/214 Bay Street Brighton Vic 3186
Tel 03 8658 0908
Fax 03 8658 0936
Email hello@metroent.com.au
metroent.com.au

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Patient Registration Form

Referring Doctor or Allied Health Professional

First Name ..... Last Name .....

Clinic Name .....

Primary Concern to see Doctor .....

Usual GP

First Name ..... Last Name .....

Clinic Name .....

Primary Concern to see Doctor .....

Other Doctors or Allied Health Professionals

.....

How did you hear about us?

☐ Referring Doctor ☐ Friend ☐ Google ☐ Other ENT Practice

☐ Other (specify) .....

Consent (Please Tick)

☐ Yes, I agree to Dr Ryan De Freitas & Metro ENT passing on my personal details and medical information to other clinicians, hospitals and medical services if necessary for my care. I also consent to the release of health information (including test results, etc) about past and present illness to the doctor making this request. I understand this is necessary for my ongoing treatment.

☐ I consent to Dr. Ryan De Freitas & Metro ENT's use of medical transcription software to assist in documenting clinical notes. This tool helps health practitioners record accurate notes during patient consultations by listening in the background and capturing only relevant details for clinical documentation. These details are then transcribed into text and sent to your health practitioner's Electronic Medical Record system.

First Name ..... Last Name .....

Relationship .....

Date ..../..../.... Signature .....

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