HearSmart
Hearing Solutions

WAX NEW PATIENT FORM

Date: _____

Title: Dr ❑ Mr ❑ Mrs ❑ Ms ❑ Mst ❑ Miss ❑ Prof ❑ Sr ❑ Fr ❑

Surname: _____ Date of Birth: _____

Given Names: _____

Residential Address: _____

Contact number: _____ Email Address: _____

Pension No: _____

☐Medicare No: _____

Doctor's Name and Address: _____

How did you hear about us? _____

☐ I agree to receive marketing material

Alternate contact No: (in case of unexpected cancellations)

Name: _____ Relationship to Patient: _____

Contact number: _____

Are you on Blood Thinning Medication **yes ❑** **no ❑**

Do you have any other hearing issues/concerns: _____

_____

By signing below, you consent to the collection, use and disclosure and handling of your personal information in accordance with the Privacy and Consent Notice. (As below)

Signature of patient _____ Date: _____

PRIVACY NOTICE AND CONSENT INFORMATION

PRIVACY POLICY: At Hearsmart, it is our policy to respect the confidentiality of information and the privacy of individuals and the individual's right to access personal information we hold. Our privacy policy is bound by the information Privacy Principles contained in the Privacy Act (Cth). Hearsmart follows the Australian Privacy Principle 5 (APP 5) (updated Privacy Act 1988 (Cth)) and Guidelines for Federal and ACT Government Websites produced by the Office of Federal Privacy Commissioner. When you visit Hearsmart for a hearing test, with your consent, we collect personal information which will be used by us for Quality Hearing Care. We understand that you are happy for us to retain your information for these purposes. If you have any questions or complaints, please contact us.