A/PROF NICHOLAS COX

Consultant & Interventional Cardiologist

MBBS FRACP FCSANZ
Clinical Associate Professor
University of Melbourne
Provider No. 214245PL

Ph: 9421 2155
www.nicholascox.com
reception@melbournecardiology.com.au

Patient Registration Form

Surname: _____

Given Names: _____

Home Address: _____

_____ Post Code: _____

Postal Address: ☐ Same as above

_____ Post Code: _____

Medicare Number: ☐☐☐☐ ☐☐☐☐☐ ☐

Reference Number (next to patient's name): ☐

Do you have **private health insurance?** ☐ No ☐ Yes

Name of Fund: _____

Membership No: _____

Title: ☐ MR ☐ MISS ☐ MRS ☐ MS Other: _____

Date of Birth: _____

Contact Information:

Home: _____

Mobile: _____ (SMS reminders)

Work: _____

Email: _____

☐ DVA: _____

☐ Overseas student/visitor from: _____

Next of Kin:

Name: _____

Relationship: _____ Ph: _____

Referring Doctor:

Name: _____

Address: _____

_____ Post Code: _____

Phone: _____

GP Details *(if different from referring doctor):*

Name: _____

Address: _____

_____ Post Code: _____

Phone: _____

Other Medical Specialists involved in your care: _____

Previous Pathology or Imaging company: _____

It is often helpful to be able to obtain old results and reports from doctors and hospitals. If you are happy for us to do so, please indicate below.

☐ I authorise the release of medical records, results and personal information (related to my care) to A/Prof Nicholas Cox.

AI Scribe Consent

A/Prof Cox may use Heidi Health, an AI-assisted scribing tool, to help document your consultation. It produces a draft note only; it does not make clinical decisions, and your doctor reviews and is responsible for all documentation. Audio is processed in real time and is not stored; the transcript and note form part of your clinical record (retained for at least 7 years, or until age 25 for patients under 18). Data is processed and stored in Australia under the Privacy Act 1988 (Cth), is not used to train AI models and is not sold. Consent is voluntary and may be withdrawn at any time, including during a consultation, without affecting your care. If you decline, another documentation method will be used. Privacy questions can be directed to the practice manager or the OAIC (oaic.gov.au).

☐ **I consent** to the use of an AI scribe during my consultations. ☐ **I do not consent**

Name: _____ **Date:** _____

Signature: _____ If signing for the patient, relationship: _____

Your signature confirms the authorisation and AI scribe choice ticked above.