CONFIDENTIAL PATIENT INFORMATION SHEET

SURNAME: .... Dr... Mr... Mrs... Ms... Miss... Mstr....

GIVEN NAME/S: .... (Defence only) RANK: ....

DATE of BIRTH: ..../......../........

ADDRESS: .... SUBURB: ....

Postcode: .... Occupation: ....

PHONE: H (......)..................................... W (......)......................................Mobile..

Do you require an interpreter or language assistance? YES / NO

Next of Kin: .... Contact Number: ....

If patient under age 16 – Parent details:

Surname.. Given name/s...DOB......../......../........

Medicare card ref: .... (this is for online Medicare Claiming only)

Email Address: ....

MEDICARE CARD NUMBER: __ __ __ __ __ __ __ __ __ __ **Exp:** ..../.............. **Ref**: ....

PRIVATE INSURANCE NAME: .... Number: ....

VETERANS' AFFAIRS CARD NUMBER: .... Gold/White

REFERRING DOCTOR .... GP ....

*Person/Company responsible for account **if not** as above, Parent, Insurance Company, Employer:*

....

PERSONAL MEDICAL INFORMATION

Weight: .... Height: .... BMI:..

Known Drug Allergies

....

Current Medications (including vitamins)

....

Are you a smoker? Yes / No

List previous illnesses or operation...

Do you take any of the following drugs daily?

Aspirin or Disprin	Yes / No	Insulin	Yes / No
Warfarin, Heparin or Xarelto	Yes / No	Cartia, Cardiprim or Plavix	Yes / No
Clopidogrel	Yes / No	Have you ever had Hepatitis?	Yes / No
Fish Oil	Yes / No	Are you HIV positive?	Yes / No

Please turn the page ››

CONSENT FORM

We require your consent to collect personal information about you. Please read this information carefully and sign where indicated below.

The medical practice collects information from you for the primary purpose of providing quality health care. This means we will use the information you provide in the following ways:

- To properly assess, diagnose, treat and be proactive in your current and subsequent health needs,
- Administrative purposes in running our medical practice
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements. It may also be necessary to disclose this information to fulfil a medical indemnity insurance obligation.
- Disclosure to others involved in your health care. This may occur through referral to other health professionals or for medical testing or investigations.
- Disclosure to other doctors in the practice or registrars attached to the practice for the purpose of your care and for teaching purposes.
- Disclosure for research and quality assurance activities to improve individual and community health care and practice management.

I have read the information and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling patient information.
I understand that I am not obliged to provide any information requested of me but that my failure to do so might compromise the quality of the health care and treatment given to me.
I am aware of my right to access the information collected about me, except in some circumstances where access might be legitimately withheld. I understand I will be given an explanation in these circumstances.
I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure that I notify this practice of.

Signed: .... Date ....

PHOTOGRAPHY

I consent to photographs being taken pre-operatively and post-operatively. These will not be used for any other purpose other than as a record on my personal file.

Signed: .... Date ....

I consent to these photographs also being used for educational, instructive purposes or promotional activity. They may also be used to demonstrate operative results to prospective patients while ensuring my absolute confidentiality. I understand I can withdraw my consent at any time.

Signed: .... Date ....

Office Use Only:
Photos Taken: Date: ....
Weight:...

Operator: ....