PATIENT INFORMATION

PLEASE COMPLETE – AS SHOWN ON MEDICARE CARD

Please tick ✓ ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr

First Name: _____ Surname: _____

Middle Name: _____ Known As: _____

Address: _____

_____ Postcode:_____

Date of Birth: _____ Gender: _____

Marital Status: _____

Contact Numbers: h) _____ w)_____ m)_____

Patient's Occupation: _____

Emergency Contact/Next of Kin: _____

Phone No: _____

Relationship to Patient: _____

REFERRED BY: _____

Address: _____

_____ Postcode:_____

Phone No: _____

OPTOMETRIST: _____

Address: _____

_____ Postcode:_____

Phone No: _____

GENERAL PRACTITIONER: _____

Address: _____

_____ Postcode:_____

Phone No: _____

Medicare No: _____ Ref No: _____ Expiry: _____

Veterans' Affairs card? ☐ No ☐ Yes - *Card number:* _____

Health Care Card or Pension Card? ☐ No ☐ Yes - *Card number:* _____ *Exp:* _____

Private Health Insurance? ☐ No ☐ Yes – *Name of Fund*: _____

Card Number: _____

Date Form completed: _____

CONSENT FORM

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

This medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. This means we will use the information you provide in the following ways:

1. Administrative purposes in running our medical practice.

2. Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.

3. Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice who have treated you or may treat you in the future. This may occur through referral to other doctors, hospital emergency departments or for medical tests and in the reports or results returned to us following the referrals. If these providers share information with us, this will also form part of your clinical record.

I have read the information above 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 legitimately be withheld. I understand I will be given an explanation in these circumstances.

I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.

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 of which I may notify this practice.

Signed …….. Date: .....
Patient Name (Block Letters): .....