PATIENT INFORMATION & CONSENT FORM

Title: Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Other ☐

Surname: Given Names:

Date of Birth: / / Known as:

Residential Address:

Suburb: Postcode:

Postal Address:

Phone: Home Work Mobile

Email:

I consent to receving reminders & notifications via SMS	Yes ☐	No ☐
I consent to receving reminders & notifications via EMAIL	Yes ☐	No ☐
I consent to receving a patient survey via EMAIL	Yes ☐	No ☐

Medicare Number: Ref No [next to your name]: Expiry: /

If Patient under 18 Parent/Guardian Name: DOB: Ref No:

DVA Number: Gold ☐ White ☐ Disability:

Pension/Health Care Number: Expiry: / /

Private Health Fund Name: Fund Number: Hospital Cover: Y ☐ N ☐

Is your treatment covered under Workcover / Third Party Insurer: Y ☐ N ☐ ******Complete claim form provided***

Usual General Practioner:
[Must be completed] Suburb/Clinic:

Referring Doctor: Suburb/Clinic:

Emergency Contact Name: Phone: Relationship:

I GIVE / DO NOT GIVE consent for my Emergency Contact person listed above to communicate on my behalf with the practice about my medical care/treatment

YOUR INFORMATION & PRIVACY DISCLOSURE…

- *I agree & acknowledge my consent is required for this practice to collect/store my personal & health information, as well as to disclose information to others involved in my health care management, including treating doctors & specialists, allied health professionals outside this practice, Work Cover, Medicare & any disclosure of the medical tests or reports that are relevant to my ongoing treatment.*
- I acknowledge *No access to my medical records will be provided to any other unauthorised person or organisation i.e. solicitor, insurance companies etc. without my express written consent.*
- I agree & acknowledge that all information provided is true & correct to the best of my knowledge.
- *I agree & acknowledge that I am responsible for full payment of today's consultation fee as a private patient along with any subsequent review appointment fees (not applicable to Work cover or Third party patients, where payment has already been pre-approved/authorised)*

Patient/Guardian Signature: **Date:** / /

You will be required to complete a medical history form on arrival for your appointment……