Patient Information Sheet

Mr/Mrs/Ms/Miss/Master_____ _____ _____
Title (Circle one) **First Name** **Surname**

Date of birth_____

Address: _____ **Home Phone**_____

Suburb_____ _____**Work Phone**_____

State_____ **Postcode**_____ _____**Mobile**_____

Email_____ _____ _____

Person responsible for all accounts: _____ **Medicare Number:** _____ **Ref:** _____ **Exp:**_____
REQUIRED FOR ELECTRONIC MEDICARE CLAIMING

Parents details: Mother _____ **DOB:** _____ **Mobile:** _____

Father _____ **DOB:** _____ **Mobile:** _____

Patient Medicare Number: _____ **Reference :** _____**Expiry:** _____

Private Health Fund _____ ____ **Membership No.** _____ **Length of Membership**: _____
Ancillary / Hospital cover (please circle)

DVA Card Number_____

Referring Doctor_____ Specialist/GP referral (circle one)

Usual GP (if different from above)_____ **Usual GP Phone No**_____
Are there other medical practitioners you would like correspondence to be sent to apart from your referring doctor and usual GP?
If so, please list then:
Name Address Phone
_____

CONSENT TO COLLECT PATIENT INFORMATION

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 medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. 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 as advised by you.

- I understand the reasons why my information must be collected.
- 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 purpose other than the above, my consent will be sought.
- 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.
- I give consent for electronic communications via Fax/Email/SMS between myself, Mr George Sims rooms and other relevant health care providers in regards to my medical care.
- My signature below indicates that I have read the above and consent to Dr Sim collecting, using, storing and disposing of my personal information and allows the release of relevant personal information to other health professionals, to allow quality medical care.
- I understand that I am responsible for all accounts raised by this practice and any collection and administration fees where necessary.

_____
Person Responsible for all Accounts (Please print)

Signature: _____Date: _____