Patient Information Sheet

Mr/Mrs/Ms/Miss/Other (circle one)

First Name: **Surname:** **Date of Birth:**

Address: **Suburb:** **Postcode:**

Home/Work Ph: **Mobile:** **Email:**

Medicare No: **Expiry:** **Parent/Gaurdian's Name if under 18 y/o:**

Private Health: **Membership No:** **Pension/DVA Card No:**

Referring Doctor: **Practice/Medical Centre:**

Usual GP (if different from above): **Usual GP Ph/Medical Centre:**

Are there other medical practitioners or physiotherapist you would like correspondence to be sent to apart from your referring doctor and usual GP? If so, please list then:

Name: **Address:** **Ph:**

Treatment area/ condition/ injury:

Are you making a claim for compensation? Please tick: Yes [ ] No [ ] Worker's Compensation [ ] CTP [ ] Sports Insurance [ ]

Claim No: **Insurance Company:** **Date of injury:**

Case Manager: **Address:** **Ph No:**

Employer: **Address:** **Ph No:**

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.

_____

Patient's Name (Please print)

_____ | _____

Signature Date

How did you hear about our practice, Complete Care Orthopaedic and/or Dr. George Gayagay (you may tick more than one):

[ ] GP/Specialist referral [ ] Internet search ie. Google [ ] Word of mouth [ ] Family/Friend

[ ] Our website [ ] Other (please specify) _____