Patient Information Sheet

Mr/Mrs/Ms/Miss/Other **First Name**______________________**Surname**______________________

Address____ **Home Phone**__________________

Suburb____**Work Phone**__________________

State_____________ **Postcode**___________ **Mobile**__________________________

Date of birth______________________**Email:** ____

Medicare No.___________________________ **Reference on card**__________ **Expiry**______

Private Health Fund ______________ **Membership No.** ______________________**Ref**____

DVA Card Number__________________ **CardColour**___________ **Disability**______________

Referring Doctor____

Usual GP ___________________________________**Usual GP Phone No**__________________

Why did you choose Dr Wilkinson? (please indicate) Referred by GP or Other________________

Next of Kin/Emergency Contact

Name_____________________ Relation______________________ 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.

Signed____ **Date:**______________________

Patient Name (Please print) ____________________________