

Dr David Wilkinson

MBBS, FRACS

Specialist Thyroid and Parathyroid Surgeon

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Patient Information Sheet

Mr Mrs Ms Miss Other

First Name _____ Surname _____ Date of Birth _____

Address _____ Suburb _____

Post Code _____ Phone _____ Mobile _____ Permission to SMS YES NO

Email: _____

Medicare No. _____ Reference on card _____ Expiry _____

Private Health Fund _____ Membership No. _____ Ref _____

DVA Card Number _____

Referring Doctor _____

Usual GP _____ Usual GP Phone No _____

Why did you choose Dr Wilkinson? (choose one)

Word of mouth (family/friend) Internet GP Specialist 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.

I also consent to communications being sent by email when appropriate. YES NO

Signed _____

Date: _____