PATIENT INFORMATION

Title _____ First Name _____ Surname _____

Known as _____ DOB _____

Hm Phone _____ Work Ph _____

Mobile _____ Email _____

Physical Address _____

_____

_____

☐ Caucasian

☐ Asian

☐ African

☐ Other

Postal Address _____

(If different from above) _____

Contact or Next of Kin _____

GP: Name & address _____

Referring Doctor _____

(If different from above)

Medicare no _____ ref ( ) expiry /

Health Fund _____ M'ship no _____

Have you been admitted to hospital in the last three years? Yes / No

If yes, where _____ When _____

PERMISSION TO COLLECT AND STORE INFORMATION

We need to collect and store some information about you:
To help us provide good and safe treatment and to provide Government bodies with information to which they are legally entitled.

We undertake: only to collect information which is appropriate to your total care, only to use the information for its intended purposes, to keep the information in your medical file and/or in our computer system, only to allow authorised staff to use that information, only to pass on to government bodies that information to which they are legally entitled, to allow you to check the accuracy of any information about you and to submit written corrections which you feel appropriate.

I have read the above explanation and agree to the collection and storage of information.

Signed …… Dated ……

Relationship (eg. parent) ……