PATIENT INFORMATION

Title _____ First Name _____ Surname _____

Known as _____ DOB _____

Hm Phone _____ Work Ph _____

Mobile _____ Email _____

Physical Address _____

_____

_____

Postal Address _____

(If different from above) _____

Contact or Next of Kin _____ Mobile _____

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. These records will contain information including, but not limited to, your name, address, date of birth, Medicare number and your referring doctor's details.

We undertake only to collect information which is appropriate to your total care and to only use the information for its intended purpose. Your medical records are stored securely and can only be accessed by authorised staff. We are required to keep your records for up to seven years following your last consultation. If necessary, for the continuity of your medical care, this information may be shared with other health practitioners involved in your treatment. In certain circumstances there may be a legal obligation to disclose clinical information, for example to Government bodies. A full copy of our privacy policy is available on request.

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

Signed …….. Dated ……

Relationship to patient (where necessary, eg. parent) ……