NAME: Mr/Ms/Miss/Mrs/Dr: (Surname, Christian Name, Middle Name)	Date of Birth:

Home Address & Suburb:	Postcode:	Work Details: Occupation: Employer:
Home Ph: Mobile:		Duties Involved: Work Ph:

Medical Practitioner (If different from referring doctor)
Name:

Address:

Phone No:

Private Health Insurance Yes / No	Fund Name: No:
Medicare Number:	Expiry Date: Ref on Card:……

WorkCover or Third Party Claim: Yes / No If yes details……
(Eg. Date of injury & WorkCover claim number)

Past Medical History: Past surgical procedures:

Diabetes	Yes / No	Procedure	Year
Asthma	Yes / No		
Heart Disease	Yes / No		
Blood pressure	Yes / No		
Deep Vein Thrombosis (DVT)	Yes / No		

Are you allergic to any medications: No / Yes, details……

Do you smoke: No / Yes, how much…….. Do you drink: No / Yes, how much…….

Do you play any sports, have any regular recreational activities or hobbies:

No / Yes, details……

Do you take regular medications: No / Yes, details……

Next of Kin:

Relationship to you:

PATIENT CONSENT FORM

Due to the new Federal Privacy Act which came into practice on December 21, 2001 this medical practice requires your consent to collect personal information about you. Please read this information carefully and sign where indicated below.

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 a full medical history so that we may properly assess, diagnose, treat, and be proactive in your health care needs. In addition we will use the information you provide in the following ways;

- Administrative purposes in running our medical practice
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements
- Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports/results returned to us following the referrals.
- Notification to Queensland Health of certain diseases as required by law.

I …… (Please print clearly) have read the information above and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling patient information.

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 other purpose other than set out above, my further consent will be obtained.

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 that I specify.

Patient signature : ……Date: ……./……./…….

(If Parent / guardian/ other – please specify……..)