Dr Philip Dalton

BPhty (Hons), MMedSc, MBBS (Hons), FRACS, CIME

Orthopaedic Surgeon

Senior Lecturer University of Qld

Greenslopes QLD 4120

Provider Number: 2203741F

Greenslopes Private Hospital

Ramsay Specialist Centre

Suite 324

Newdegate Street

Telephone: 07 3394 2055

Facsimile: 07 3394 2066

Also visiting:

Sunnybank Private Hospital

Mater Private Hospital Redlands

ABN: 65 442 282 278

NAME: Mr / Mrs / Ms / Miss / Dr

Surname: ..... Given name/s: ..... Known as: .....

Address: .....

..... Date of birth: ..... / ..... / .....

Phone contacts: ..... (home) ..... (mobile) ..... (work)

Next of kin name: ..... Relationship to you: ..... Contact no. .....

WORK DETAILS:

Occupation: ..... Employer: .....

Duties involved: .....

Medicare no: __ __ __ __ __ __ __ __ __ __ (10 digits) Reference: ..... (no. in front of your name) Expiry: ..... / .....

Private Health Insurance: No / Yes Fund: ..... Member No.: .....

DVA card: No / Yes If yes, Number: .....

Gold / White If white, condition/s covered: .....

Medical Practitioner (if different from referring doctor):

Name: ..... Phone no. .....

Address: .....

WorkCover or Third Party Claim: No / Yes - If yes, Employer name / address OR Insurer name / address:

.....

Claim number: ..... Case manager: .....

MEDICAL HISTORY:

Diabetes:	No / Yes
Asthma:	No / Yes
Heart Disease:	No / Yes
Blood Pressure problems:	No / Yes
Deep Vein Thrombosis (DVT):	No / Yes

PAST SURGICAL PROCEDURES:

Procedure	Year

Are you allergic to any medications? No / Yes - details .....

Do you smoke? No / Yes – how much? .....

Do you drink alcohol? No / Yes – how much? .....

Do you play sport, or have regular recreational activities or hobbies? No / Yes – details .....

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Do you take any regular medications (including vitamins)? No / Yes – details .....

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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.....)