Dr Philip Dalton

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Orthopaedic Surgeon

Senior Lecturer University of Queensland

Provider Number: 2203741F

Patient Registration Form

To ensure your medical record is accurate, please complete the following information, which will remain part of your medical file.

PERSONAL DETAILS

NAME: Mr / Mrs / Ms / Miss / Dr / ....

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

ADDRESS: ....

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

PHONE CONTACTS: (mobile) ....home) .... (work) ....

Are you willing to receive appointment reminders by text message? *Yes* *No* ....*(initials)*

NEXT OF KIN: .... Relationship to you: .... Contact no. ....

Are you willing for us to speak to this person if we are unable to contact you? *Yes* *No* ....*(initials)*

YOUR EMAIL ADDRESS: ....

Our Practice uses email as a form of communication. Do you consent to receiving email? *Yes* *No* ....*(initials)*

Please note: Email and SMS forms of communication are not encrypted. This means that email and SMS are not guaranteed to be secure. Agreeing to receive private & confidential results or correspondence is at your own risk.

Usual Medical Practitioner (if different from referring doctor):

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

Address: ....

WORK DETAILS

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

Duties involved: ....

INSURANCE DETAILS

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: ....

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

....

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

EMERGENCY CONTACT

Name: .... Relationship to you: .... Contact No: ....

Are you willing for us to speak to this person if there is an emergency? *Yes* *No* ....*(initials)*

MEDICAL HISTORY Have you any history of:

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

PAST SURGICAL PROCEDURES and approximate dates

....

....

GENERAL

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 ....

....

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

....

PATIENT CONSENT

Amendments to the Privacy Act 1988 have seen the introduction of the Australian Privacy Principles (APPs), replacing the current National Privacy Principles (NPPs) from 14 March 2014. These amendments redefine how healthcare services can manage your 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 full medical history so that we may properly assess, diagnose, treat, and be proactive with regard to 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 .... (print name 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 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 ....)