Patient Information Sheet

Dr Danielle Delaney, MB BS (Syd), FRACS

Please complete the following information and return to us at the time of your appointment

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Patient Details:

Title: ☐Mr ☐Mrs ☐Miss ☐Ms ☐Dr **Date of Birth: ____/_____/_____**

Surname: _____ **Given Name: _____**

Address: _____

Suburb: _____ **Postcode: _____**

Email: _____

Mobile: _____ **Home: _____**

Claim Details:

Name: _____ (if different from above)

Medicare Number: _____ **Position on Card:☐1 ☐2 ☐3 ☐4 ☐5**

Private Health Insurance: ☐Yes ☐No

Fund Name: _____ **Fund Number: _____**

Pension/DVA Card Number: _____ **Type (circle) Aged Pension/DVA/Other**

Referring Doctor: _____ **☐ Specialist ☐ GP Referral**

Usual GP Name (if different from above): _____

Are there any other medical practitioners you would like to have copied on correspondence apart from your referring doctor and usual GP? Please list below.

1) **Name: _____** **Phone: _____**

   Address: _____

2) **Name: _____** **Phone: _____**

   Address: _____

3) **Name: _____** **Phone: _____**

   Address: _____

Please complete the following if patient is under 18 years old

Account Holder:

Title: ☐Mr ☐Mrs ☐Miss ☐Ms ☐Dr **Date of Birth: ____/_____/_____**

Name: _____ **Relationship to Patient: _____**

Medicare Number: _____ **Position on Card:☐1 ☐2 ☐3 ☐4 ☐5**

Parent/Carer/Guardian Details: **(please include all guardian details)**

Title: ☐Mr ☐Mrs ☐Miss ☐Ms ☐Dr

Name: _____ **Relationship to Patient: _____**

Address: _____

Suburb: _____ **Postcode: _____**

Mobile Number: _____

Name: _____ **Relationship to Patient: _____**

Address: _____

Suburb: _____ **Postcode: _____**

Mobile Number: _____

Who does the patient live with? _____

CONSENT TO COLLECT PATIENT INFORMATION

Dr Danielle Delaney PTY LTD collects information from you for the primary purpose of providing quality health care.
We require you to provide us with your personal details and medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. 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 as advised by you.

I understand the reasons why my information must be collected.
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 that if my information is to be used for any purpose other than the above, my consent will be sought.
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 of which I may notify this practice.

Consent:
I consent to be contacted via the following for test results, appointments confirmations, practice updates and health information.

SMS: ☐ Yes ☐ No Telephone: ☐ Yes ☐ No Email: ☐ Yes ☐ No
I agree to my health records being reviewed as a part of quality improvement at this practice. **☐ Yes ☐ No**

Patients Name: _____ **DOB**: _____.

Signed by: _____ **Date: _____**