Personal Details

DR GREGORY COUZENS

Patient information sheet – Strictly Confidential

Title:________ First Name:______________ Surname:______________

RESIDENTIAL ADDRESS:

No:____ Street: ____________________ Suburb: ______________ P/Code: ________

POSTAL ADDRESS: PO Box:____________ Suburb:____________________ P/Code:________

DOB:___/___/____ PHONE (H):______________ (W):______________ (M):______________

Email address:______________________ Occupation: ______________________

Billing Information

Medicare No. _ _ _ _/_ _ _ _ _ _/_ Ref No.________ Expiry Date: ______/________

*Note: Ref (reference number) is the small number in front of your name on the Medicare card

Vet Affairs No:____________________ Expiry Date:_____/_____/______ White / Gold (please circle)

Is your appointment today in relation to a current or future planned medicolegal claim?______________

Have you contracted a solicitor or lawyer for your injury/claim:______________________

Work Cover Claim: YES □ / NO □ Claim No.______________________________

If not please name company handling your claim:______________________

Private Health Insurance Details

Do you have Private Health Insurance YES □ / NO□

Please indicate level of Cover: Hospital/ Hospital and extras/ Extras only

Fund Name:__________________ Membership No.:____________________

Referral Details

Referred by:______________________________ Suburb:______________________

Regular GP(if different to referring Dr):__________________ Suburb:______________________

Next of Kin/Emergency Contact

Name:__________________ Relationship:______________ Phone:______________

Medical History

Do you take regular medications: **YES** □ **NO** □ If yes please list your medications: ______________

____

Do you suffer from Allergies (medication or food) ______________________________

____

Do you suffer from: **Heart Disease YES □ / NO □** **Asthma YES □ / NO □** **Blood Pressure YES □ / NO □** **Diabetes YES □ / NO □**

Please list any past surgical Procedures:

Procedure:______________________________ Year:______________

Procedure:______________________________ Year:______________

Procedure:______________________________ Year:______________

*******Please turn over and sign the privacy consent ******

PRIVACY CONSENT FORM

We require 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 full medical history so that we may properly assist, diagnose, treat and be proactive in your health care needs. This means, 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, specialists, and allied health providers such as physiotherapists or hand therapists, outside this medical practice. This may occur through referral to other doctors, or for medical tests and the subsequent reports or results returned to us following referrals;
- Disclosure to other doctors in the practice, locums and by Registrars attached to the practice for the purpose of patient care and teaching. Please let us know if you do not want your records accessed for these purposes and we will note your request accordingly;
- Disclosure for research and quality assurance activities, to improve individual and community health care, and practice management.
- Emergency situations whereby medical officers/hospitals require access to patient notes for treatment purposes.

I 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 that I will be given an explanation in these circumstances.

Should I wish to access my information:-

I understand that this practice has a policy I must follow, which will be made available on request, and there may be an administrative charge levied for providing copies of my personal information.

I also consent to my clinical details, x-rays, MRI, CT, ultrasound scans, surgical images or any other investigations to be used by Dr Couzens and the Brisbane Hand and Upper Limb Research Institute for research, and to the use of my de-identified information for education, scientific presentations, or publication of papers or any other bone fide research and educational purposes.

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 purpose set out above, subject to any limitations on access or disclosure that I notify this practice of. These limitations will be provided by me, in writing, and will be added to my personal information already held in this practice.

Name:____

(please print name here)

Signature:______________________________ **Date:**_____ /______ /_______