Brisbane Diabetes Endocrinology

PATIENT INFORMATION SHEET

---------- CONFIDENTIAL ----------

DATE: _____

Title _____ Full Given Name(s): _____

Preferred Name: _____ Surname: _____

Home Address: _____

Suburb: _____ Postcode: _____

Postal/Billing Address: _____

Date of Birth: _____ Pension Number/ DVA Number: _____ Exp: _____

Contact Numbers: (H) _____ (W) _____ Mobile: _____

Email Address:** _____

Medicare Card Number: Expiry Date: ____/____

Person Reference Number: Or TICK if no Medicare ☐

Occupation: _____

Private Health Fund: _____ Member Number: _____

Referring Doctor: _____

Local Doctor (if different from referring Doctor): _____

Address: _____

Emergency Contact Person:

Name: _____ Relationship: _____

Contact Numbers: (H) _____ (W) _____ Mobile: _____

Medical History

ANY KNOWN DISEASES IN FAMILY: _____

PREVIOUS SURGERY DETAILS (INC. DATES): _____

_____

_____

ALLERGIES: _____

SMOKER: YES/NO ALCOHOL: YES/NO APPROX PER WEEK: _____

MEDICATIONS: _____

Brisbane Diabetes Endocrinology

PATIENT INFORMATION SHEET

---------- CONFIDENTIAL ----------

PRIVACY IN OUR MEDICAL PRACTICE

We value the doctor-patient relationship. Patient privacy is vital to such a relationship. The Privacy Act 2009 and its recent amendments formalize the already existing and acknowledged privacy obligations of our practice.

Our doctors and staff collect information from patients primarily to provide proper care and treatment. We have a legal and ethical duty to protect patient information. Patient information may have to be disclosed to other doctors, nurses, therapists and health care providers and health administration services, so that proper health care is not compromised.

The doctors in this practice are members of various medical and professional bodies including medical defence organizations. The organizations provide valuable services to their members. They require their members to provide information in relation to their medical practice, which may include patient information. General patient information is used for:

- Administrative purposes in running the medical practice
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- To other medical practitioners, hospitals or health service providers including locums to assist in current or future treatments that relate to the condition you are currently being treated for, or subsequently arise, as either an outpatient or inpatient.
- Disclosure to medical defence organizations.

In addition

- The Practice has a Privacy Policy on handling patient information.
- Patients are encouraged to provide information requested of them. Failure to do so may compromise the quality of health care and treatment given.
- The patient **must** notify the Practice of limitations to access or disclosure of personal information excluding the purposes outlined above e.g. administrative billing etc. If the personal information is to be used by the Practice for any other purpose the patient's consent must be obtained.

**E-Mail

- E-Mail addresses supplied will mainly be used for appointment confirmation/changes
- E-Mail may also be used if we are unable to contact you otherwise regarding results/medications
- As we cannot guarantee the length of time to reply to e-mail – please DO NOT e-mail doctors regarding urgent medical matters

ACCESS TO PERSONAL INFORMATION

Accessing personal health information from this Practice can be arranged on request. This should follow discussion with the treating doctor.

A 'Request for Access' form is to be completed and a fee will be payable by the patient to cover administrative costs

Access can be legitimately withheld under certain circumstances. An explanation will be given in these circumstances by the treating doctor.

PATIENT CONSENT

I have read and understand the purpose of collection of personal information. I consent to the handling of personal information as outlined above. I will notify the Practice of additional limitations on access or disclosure.

Patient Name _____

Signed _____ Date _____
Patient Signature

Signed _____ Date _____
Guardian/Responsible Person/Statutory Health Attorney