Central West Specialists

TITLE (please circle) DR / MR / MRS / MAST / MISS / MS **SURNAME** ______________________

GIVEN NAMES ______________________

ADDRESS ______________________

______________________ POSTCODE ______________

DATE OF BIRTH ______/______/______

TELEPHONE: Home ______________ Mobile ______________ Work ______________

EMAIL ______________________ Preferred telephone contact ______________

OCCUPATION ______________________ MARITAL STATUS ______________

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MEDICARE NUMBER ______________________ REF NO: ________ EXP DATE ________
Medicare Reference number is the number at the beginning of each individual person on your card.

PRIVATE FUND ______________________ MEMBER NUMBER ______________ REF NO ______

PENSION NUMBER ______________________ EXPIRY DATE ______________

VETERANS AFFAIRS (DVA) NUMBER ______________________ EXPIRY DATE ______________

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REFERRING DOCTOR ______________________ Phone ______________

USUAL GP ______________________ Phone ______________

USUAL PHARMACY ______________________ Phone ______________

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**ACCOUNT HOLDER (If patient is a child)** TITLE _____ NAME ______________________

DATE OF BIRTH ______/______/______ MEDICARE NO. ______________________ REF NO. ______

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**NEXT OF KIN** TITLE ______ SURNAME ______________ FIRST NAME ______________

CONTACT NO: ______________ RELATIONSHIP: ______________

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ALLERGIES ______________________

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I GIVE CONSENT TO THIS PRACTICE SMS / EMAILING APPOINTMENT CONFIRMATIONS YES NO

HOW DID YOU CHOOSE THIS SURGERY?

- ☐ WEBSITE
- ☐ INTERNET
- ☐ GP Referral
- ☐ Friend / Relative
- ☐ YELLOW PAGES
- ☐ OTHER

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**PAYMENT IS EXPECTED ON DAY OF CONSULTATION. EFTPOS FACILITIES ARE AVAILABLE.**
**QUERIES REGARDING FINANCIAL ARRANGEMENTS CAN BE DISCUSSED WITH THE ACCOUNTS MANAGER.**

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**IF WORKERS COMPENSATION OR THIRD PARTY CLAIM, PLEASE FILL OUT SECTION ON THE BACK OF THIS FORM**

**PTO – for WorkCover information and Privacy Act consent**

## WORKCOVER

**EMPLOYER** ______________________________________________

ADDRESS ______________________________________________

______________________________________ POSTCODE ______________

Telephone: ________________ Facsimile ______________ Email ______________________

TYPE OF INJURY ______________________________________________

HOW INJURY OCCURRED ______________________________________________

DATE OF INJURY _______/_________/________

CLAIM NUMBER ______________________ CASE MANAGER ______________________

**INSURER** ______________________________________________

ADDRESS ______________________________________________

______________________________________ POSTCODE ______________

Telephone: ________________ Facsimile ______________ Email ______________________

DUST DISEASES BOARD REFERENCE NUMBER: ______________________________

**Privacy Information and Consent Form**

We may disclose personal information to your referring doctor, general practitioner and other health providers, in providing medical treatment and care for you. We may also need to obtain your medical records from other organisations in order to assist in your diagnosis and/or treatment. We may also disclose personal information to other institutions for purposes directly associated with your treatment.

In cases where a medical practitioner requests a copy of your reports and our staff is satisfied that the practitioner is currently treating you, we will release that report to the practitioner without specifically requesting your consent. This is to prevent any undue delay in your treatment.

Sometimes we are required by law to disclose your personal information e.g. in response to a court subpoena.

Central West Specialists will destroy or de-identify any personal information after its legal obligations to retain the information has expired.

I am aware that the encryption of emails and provision of anti-virus sent from me is my responsibility and that the practice takes no responsibility for any disclosure, loss or damage that occurs as a result of my failure to encrypt emails or to ensure that my emails are virus free.

I acknowledge that I have read this form before signing it and that a member of the staff of this practice has at my request clarified any aspects of it that I did not at first understand.

**I hereby authorise Central West Specialists to obtain or release from / to relevant parties, all medical records relevant to my treatment and diagnosis.**

______________________________ ______________________________

Patient's Signature Date