Patient Information Sheet

WA SURGERY

Mr/Mrs/Ms/Miss/Other_____ _____

Title (Circle one) **First Name** **Surname**

Date of birth_____

Address: _____ _____ **Home Phone**_____

Suburb_____ _____**Work Phone**_____

State_____ **Postcode**_____ _____**Mobile**_____

Email_____ _____

COVID Vaccination status: (circle) Vaccinated / Unvaccinated / Exempted

Next of Kin details:
Name: _____ **Relationship:** _____

Contact number: _____ **Email:** _____

Medicare No._____ _____**Reference on card**_____

Private Health Fund_____ **Membership No.** _____ ___**Ref**_____

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

Referring Doctor_____ Specialist/GP referral (circle one)

Usual GP (if different from above)
Name: _____ **Phone No**_____

Address: _____

Are there other medical practitioners you would like correspondence to be sent to apart from your referring doctor and usual GP?
If so, please list then:

Name Address Phone

CONSENT TO COLLECT PATIENT 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 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:

1. Administrative purposes in running our medical practice.
2. Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
3. 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 I will be given an explanation in these circumstances.
- 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.

_____

Patient's Name (Please print)

_____ _____

Signature Date

CONSENT TO FINANCIAL RESPONSIBILITY

I understand that fees are due and payable on the date that the services are rendered.
I accept all financial responsibility for medical services rendered to myself by Mr. MAYANK BHANDARI, regardless of my insurance benefits.

_____

Name of person responsible for finances (Please print)

_____ _____

Signature Date