

# Patient Information and Privacy Form

## PATIENT DETAILS:

Given Name: \_\_\_\_\_ Surname: \_\_\_\_\_

DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Mobile Ph: \_\_\_\_\_ Home Ph: \_\_\_\_\_

EMAIL: \_\_\_\_\_

Residential Address: \_\_\_\_\_

Medicare no: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Medicare Patient ref no: \_\_\_\_\_ Expiry: \_\_\_\_ / \_\_\_\_

Health Fund: \_\_\_\_\_ Fund No: \_\_\_\_\_

Pension no: (if applicable) \_\_\_\_\_ Expiry: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

DVA (Veterans Affairs) No: (if applicable) \_\_\_\_\_ Colour: \_\_\_\_\_ Expiry: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Next of Kin: Name: \_\_\_\_\_ Contact numbers: \_\_\_\_\_

Relationship (eg mother, partner, son, friend) \_\_\_\_\_

## **For Parents/Carers of children under 16 ONLY:**

Parent/Carer Full Name: \_\_\_\_\_ Parent/Carer DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Parent/Carer Medicare ref no. \_\_\_\_\_

## MEDICAL HISTORY:

Are you currently or do you have a history of heart disease and or diabetes (please specify)

\_\_\_\_\_

Please list all current medications if not on your referral: \_\_\_\_\_

\_\_\_\_\_

Please list all allergies and reactions (eg Sulphur – rash) \_\_\_\_\_

\_\_\_\_\_

## **HEALTHCARE PROFESSIONALS:**

### **USUAL GP DETAILS:**

Please tick  if same as your referring doctor  (Do not fill in GP details below if you have ticked box)

GP Name: \_\_\_\_\_ Suburb: \_\_\_\_\_ Ph: \_\_\_\_\_

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Please details of any other specialists you are currently under and / or audiologist (if applicable)

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ Ph: \_\_\_\_\_

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ Ph: \_\_\_\_\_

### **Audiologist (if applicable)**

Please tick if you attend one of our affiliated Audiology clinics...

Lindfield Audiology, Lindfield      or       Attune Hearing, Crows Nest

Or please complete below if you went to another audiology clinic not listed above.

Clinic Name: \_\_\_\_\_ Audiologist Name: \_\_\_\_\_

Suburb: \_\_\_\_\_ Ph: \_\_\_\_\_ Date last Attended: \_\_\_\_/\_\_\_\_/\_\_\_\_

### **PRIVACY:**

This practice respects and upholds your right to privacy protection as set out in the Privacy Act 1998. Information collected from you is for the primary purpose of providing quality health care. We require your personal details and full medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. This practice will use the information you provide for the following;

- 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 of this medical practice.
- 4/ May be used for research and teaching purposes. Our ENT's are heavily involved with both research and teaching of other surgical colleagues, trainees, and students. De-identified (anonymous) data including videos or pictures taken are essential for this purpose along with patient's medical history, symptoms and diagnosis. Please note that patient's names or identity (e.g. face) are never revealed but are kept completely confidential.
- 5/ In the interests of open disclosure, please note that from time to time, Dr Kong may own a small parcel of Cochlear Ltd shares. He never allows this to have any influence on any clinical recommendations or discussions he makes.

I have read the information above and understood the reasons why my information is to 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 have read and understood the above information.

Signed: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Please print name: \_\_\_\_\_