Patient Information & Consent Form

Title: □Dr □Mr □Mrs □Ms □Miss □Master ***Email:***_____

Surname*:**_____ **First N*ame*:**_____Middle Initial*:**_____

Known As*:**_____DOB:***_____

Address:_____

Suburb:_____***State:***_____***Post Code*:**_____

***Postal Address*:**_____

***Medicare No*: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___** ***Reference No*: ___** ***Exp Date*: __ __ /__ __ __ __**

Health Fund: □Yes □No

***Health Fund Name*: _____** ***Member No*: ___ ___ ___ ___ ___ ___ ___ ___** ***Ref No*: ___ ___**

Level of Cover □Private □Intermediate □Extras

***Who Is Your Regular GP*:**_____ **Practice Name: _____**

***Marital Status*:** □Single □Married □Widowed □Divorced □Separated □DeFacto

Country of Birth*:**_____Primary Language:***_____

Occupation Status: □Employed □Unemployed □Self Employed □Pensioner □Retired

Occupation:_____

Name Of Next Of Kin*:**_____Relationship*:**_____

Address:_____

***Home Phone No*:**_____ ***Mobile*:**_____

***Do You Have Any Allergies*:** □Nil Known □No □Yes (Please List)

_____

Are You Diabetic? □Yes □No **If Yes, Type: _____**

Please complete this section as we require your consent to collect personal information about you.

Please read this information carefully and sign where indicated below.

Privacy Policy & Agreement

Dr Barui collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose treat and be proactive in your health care needs. This means we will use the information you provide in the following ways:

- **Administration purposes required to run our medical practice.**
- **Billing purposes for compliance with Medicare and Health Insurance requirements.**
- **Disclosure to other health care providers including treating doctors, specialists and allied health carers outside this medical practice. This may occur through referral to other doctors, medical facilities which we refer for medical tests to be carried out and also in reporting of the results which are forwarded to us after your tests are completed.**

- **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.**
- **I am aware of my right to access the information collected about me, except in some circumstance 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 other purposes other than those set out above, further consent will need to be gained by the practice.**
- **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 that I notify this practice of.**
- **I consent to this surgery contacting other Medical facilities to obtain medical records pertaining to my medical history.**
- **I consent to my next of kin or person nominated by myself to discuss my medical condition when necessary with Dr Barui.**

Financial Information & Agreement with Dr Barui:

All accounts are to be fully paid at the time of consultations. Any problems need to be raised with staff *prior* to the consultations. We are *not* a bulk billing practice.

I have read the information above and understand the reasons why my information must be collected. I also understand and agree to the billing policy of Dr Barui.

***Print Name:*_____ D*ate:*_____**

Signature: _____

(Either sign with an esignature or at your first appointment)