PATIENT INFORMATION AND CONSENT FORM

SURNAME .....MR/MRS/MS GIVEN NAMES ..... AGE: .....

DATE OF BIRTH ..... TELEPHONE (HOME) .....

TELEPHONE (WORK)..... MOBILE NO.....

***ADDRESS* (PRINT).....**

EMAIL ADDRESS: ……
(PLEASE PRINT CLEARLY-SURGICAL INFORMATION MAY BE EMAILED)

HEALTH INSURANCE FUND..... HOSPITAL COVER YES/NO

MEMBERSHIP NUMBER .....

MEDICARE NUMBER __ __ __ __ __ __ __ __ __ __ __ Ref No __ Expiry date __ __ / __ __

COMMONWEALTH AGE PENSION NUMBER: ..... Exp .....

VETERAN AFFAIRS GOLD CARD NUMBER .....

NAME OF GP: .....

DRUG ALLERGIES: .....

OTHER CONTACT PERSON: .....TELEPHONE:……..

CONSENT: (Please read carefully and sign)

I understand that S R Baker Pty Ltd complies with the Privacy Act (2001) and as part of their Privacy Policy, they are committed to protecting the privacy of individuals and their personal information. The purpose of collecting my personal information is to provide quality medical and health related services and associated account keeping. I understand I have the right to request access to my information except where access would be denied, and that S R Baker Pty Ltd makes every effort to manage my information in accordance with the National Privacy Principles and keep my records up to date and accurate. I understand I may withdraw my consent for S R Baker Pty Ltd to use and disclose my personal information (except when legal obligations must be met).

My signature below indicates that I have read the above and consent to:

1. ***S R Baker Pty Ltd collecting, using, storing and disposing of my personal information,***
2. ***The release of relevant personal information to other health professionals (eg: Specialists etc)***
3. ***The release of relevant personal information to my (prospective) employer, their authorised representative, and their insurer in the case of a work related consultation or service.***

Signature.....Date.....