TheCardiacCentre

'your heart's in good hands'

PATIENT INFORMATION SHEET

Surname _____ **Given Names** _____

Title Mr / Mrs / Ms / Miss / Dr **Date of Birth** _____ **Country of Birth** _____

E-mail Address _____

Address _____

_____ **Post Code** _____

Postal Address _____

Home Phone _____ **Mobile** _____

Marital Status ***Single*** ☐ ***Married*** ☐ ***De Facto*** ☐ ***Widowed*** ☐ ***Separated*** ☐ ***Divorced*** ☐

Please provide Spouse/Partner's name if they are a patient of this practice: _____

Medicare Card No: _ _ _ _ _ _ _ _ _ _ _ _ _ **Exp Date:** _ _ / _ _ **Ref No** _ ***(found in front of name on card)***

Pension /HCC Number _____ **Exp. Date** _____

Do you have Private Medical Insurance? ***Yes*** ☐ ***No*** ☐

Health Insurance Fund _____ **Membership No.** _____

Dept Vet Affairs (DVA) Membership No: _____ **Expiry Date:** _____

General Practitioner _____ **Address** _____

Next of Kin: _____ **Relationship to Patient:** _____

Contact Phone Numbers (H) _____ **(M)** _____

Emergency Contact: _____ **Phone No** _____
(Different to your Next of Kin)

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 a full medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs as well as liaising with Medicare, your health fund and other health professionals involved in your care. The Practice has a privacy policy on handling patient information.

I understand the reasons why my information must be collected and am 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, 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 (e.g. Medical records sent to our practice from a third party.) I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.

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I understand that these consents may be withdrawn at my written request at any time.

SIGNATURE _____ **DATE** _____

Heartlab

'your heart's in good hands'

TheCardiacCentre

Heartlab

MEDICATION LIST

Patient Name:_____**DOB:**__/__/____

PLEASE list all the medications you are currently taking along with the dose and frequency. PLEASE bring your medication to your cardiology appointment.

DRUG NAME	DOSAGE	FREQUENCY

Patient Signature:_____ Date:__/__/____