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

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