Patient Information Sheet –DR G ROSENBERG

Family Name: _____ **First Name:** _____

Title *(circle):* Mr Mrs Ms Miss Mstr **If Child Parents Name:**_____

Address: _____

Telephone: **Home** (___) _____ **Work** (___) _____ **Mobile** _____

Date of Birth: _____ **Occupation:** _____

Private Health Fund: Yes No **Fund Name**_____**Member Number**_____

Medicare No.: _ _ _ _ _ _ _ _ _ _ **Expiry Date:**_____

Number in front of YOUR name on Medicare Card:_____

Aged Pension No.: _ _ _ _ _ _ _ _ _ _ Expiry Date:_____

Veterans Gold Card: _____

Current Medications: _____

Allergies: _____

Condition to be treated:_____

Referring Dr: _____

Family Dr (if not referring Dr): _____

Workers Compensation

Full name of employer:_____

Address: _____

Insurance Company: _____

Address: _____

Claim No.: _____ **Date of injury:** _____

PRIVACY INFORMATION AND CONSENT FORM – The law gives you certain privacy rights in relation to information that you give to this medical practice. We require your consent to collect personal information about you. The fact that you have come here implies that you consent to the Doctor knowing about your health situation either for a particular event or generally. Please read the following information about privacy issues then sign this form where indicated below.

The main reason we collect information from you is so we can assess, diagnose and treat your illness properly, liaise with your other doctors and be pro-active in your health care. We will also use the information you provide in the following ways:

- Administration of this practice
- Billing, including compliance with Medicare and Health Insurance Commission requirements

PATIENT'S ACKNOWLEDGEMENT – I have read this form and understand why collecting information about me is necessary. I am also aware that this Practice has a privacy policy on handling patient information.

Signed: _____ **Date:** _____