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PATIENT INFORMATION / PRIVACY FORM

GENERAL

Title: Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other

Last name:

First name:

Date of Birth:

Address:

Home phone: Work: Mobile:

Email address:

Next of Kin/Emergency Contact: Relationship:

Phone: (H) (M)

If we are not able to contact you, would you like us to leave a message with whoever answers the phone? Yes ☐ No ☐

Are you happy for us to confirm your appointments via SMS/text message? Yes ☐ No ☐

FINANCIAL

Medicare No: Expiry date: Reference No: (on left side of name)

Private Health Insurance: Y ☐ N ☐ Fund Name: Membership No:

Veteran Affairs No: Expiry date:

Pension No: Expiry date: Type: Aged ☐ Disability ☐ Other:

REFERRAL

Referring Doctor: Phone:

Address:

Family Doctor: Phone:

Address:

IMPORTANT INFORMATION

Pathology and Radiology Fees: Doctors are not responsible to pay the fees in relation to pathology and radiology ordered on your behalf.

Payment of Fees: Payment of fees at the time of consultation is required. Collection fees will be charged and payable on any outstanding debts.

Privacy Policy: Our staff will not disclose this information to any third party. Your information is stored on a secure password protected information system. Onward referral to another specialist will require the duplication of this form, your record and test results. If results are not received by the practice, our staff may call the organisation that performed the tests to receive a fax copy. Your records and information may be kept by your doctor at another location. Your information may be used for billing purposes including bad debt management. If you do not give permission for the above please let our receptionist know. Access to your medical records may be allowed in accordance with the appropriate section of the National Privacy Act 1988.

Signature:_____ Date: _____

Prof Carsten E. Palme MB BS FRACS

Otolaryngology Head & Neck Surgery

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PATIENT STICKER

Date: ____/____/____

Dear Patient,

Please answer the following questions regarding your current condition, past health and any regular medications that you require:

What is your current complaint? (Reason for referral)

_____

_____

A. Past Medical History:

Please TICK if you have ever experienced the following Medical problems:

- ☐ Heart (Chest pain, Heart Attack)
- ☐ Lung (Asthma, Emphysema)
- ☐ Blood Pressure
- ☐ Bleeding Problems
- ☐ Diabetes (Insulin or Non Insulin)
- ☐ Brain (Strokes)
- ☐ Kidney Problems
- ☐ Thyroid Problems
- ☐ Liver Problems
- ☐ Any Previous Cancer Treatment (i.e. Chemotherapy/Radiotherapy/Surgery)

Other Medical Problems:

_____

_____

_____

B. Past Surgery:

Please list any previous surgical procedures:

_____

_____

_____

C. Medication List:

Do you take any blood thinning medication? Yes ☐ No ■

_____

(i.e. Warfarin, Aspirin, Ibubrofen, Plavix, Iscover, Arthritis Medication)

Do you take alternative or natural medicine?
(i.e. Ginko Biloba, Ginseng, Garlic supplements, Vitamin E)

_____

_____

_____

_____

_____

_____

D. Do you have any medical allergies?

Yes / No

_____

_____

E. General History

Please TICK if you answer "YES" to:

- ☐ Are you a current smoker?
- ☐ Do you drink alcohol?
- ☐ Do you have any significant illness that runs in your family?

What is or has been your primary occupation?

_____

_____

Thank you for completing this questionnaire

Contact Details:
Secretary Phone: 1300 552 665 Fax: 8089 1025
Email: ent@specialistservices.com.au

FRACS Fellow of the Royal Australasian College of Surgeons

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Name..... DOB.....

PATIENT CONSENT FOR THE COLLECTON, USE & DISCLOSURE OF INFORMATION

The Privacy and Personal Information Protection Act 1988 require medical practitioners to obtain consent from each patient to collect, use and disclose personal medical information.

As part of our commitment to providing quality health care, it is necessary for us to maintain files pertaining to your health. The files may contain the following information:

Personal details, your medical history, notes made during each consultation, referrals and correspondence to other health care providers, results and reports from other health care providers, clinical photographs and videos.

CONSENT

I have read and understand the above statement on collection, use and disclosure of personal information by Prof Carsten Palme and Specialist Services.

I give my consent for the staff of Prof Carsten Palme and Specialist Services to collect, use and disclose my personal information as outlined above, and to use de-identified information for research or educational purposes.

I agree to information relevant to my care and treatment being requested and being provided to, health care providers who are involved in my care.

I understand that I may withdraw my consent to use and disclose my personal information (except when legal obligations must be met).

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

Please email form by clicking: Submit