Patient Information Sheet - Dr Buddhika Balalla

Mr/Mrs/Ms/Miss/Other________________ ______ ____
Title (Circle one) **First Name** **Surname**

Address:
____ ________**Home Phone**____________________________________

Suburb____ ________**Work Phone**_____________________________________

State____________________ **Postcode**______________________ ________**Mobile**____

Date of birth_______________________ **Email:** ____

Medicare No.____**Reference on card**______________ **Expiry** ____________

Private Health Fund__________________________ ____ **Membership No.** _________________________________ ___**Ref**_________

Heath Care/Pension/DVA Card Number______________________________________ **Type(circle)** Aged Pension/DVA/Other

Referring Doctor____ Specialist/GP referral (circle one)

Usual GP (if different from above)____ **Usual GP Phone No**_______________________

Are there other medical practitioners you would like correspondence to be sent to apart from your referring doctor and usual GP?
If so, please list then:

Name Address Phone

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CONSENT TO COLLECT PATIENT INFORMATION

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 medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. We will use the information you provide in the following ways:

1. Administrative purposes in running our medical practice.
2. Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
3. Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice as advised by you.

- I understand the reasons why my information must be collected.
- 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. I understand I will be given an explanation in these circumstances.
- I understand that if my information is to be used for any purpose other than the above, my consent will be sought.
- 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 of which I may notify this practice.

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Patient's Name (Please print)

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Signature Date

Work Cover or Third Party Insurance Claims

Insurance Company:

Claim Number:

Case Manager: **Phone no:**

Employer: **Contact:** **Phone no:**

Address: