

PATIENT INFORMATION SHEET:

Child's First Name: _____ **Child's** Last Name: _____

Postal Address: _____

Suburb: _____ Postcode: _____ Male / Female

Date of Birth: ____/____/____

Mother/Parent/Guardian's full name: Miss/Ms/Mrs/Dr _____

Mobile: _____

Father/Parent/Guardian's full name:Mr/Mrs/Miss/Ms/Dr _____

Mobile: _____

Email address (PRINT CLEARLY)

MEDICARE NUMBER: _ _ _ _ _ _ _ _ _ _ Expiry Date _____

REFERENCE NUMBER: () (Number on left of child's name on card)

CHILD'S PRIVATE HEALTH COVER INFORMATION

HOSPITAL COVER YES / NO **DO NOT COMPLETE IF ANCILLARY COVER ONLY**

IF YES PLEASE COMPLETE - Health Fund Name: _____

Health Fund Membership No: _____ REF: _____ **LESS/MORE 12 MONTHS:**

REFERRING DOCTOR'S NAME: Dr _____

USUAL GP ADDRESS: _____

SUBURB: _____ POSTCODE: _____

USUAL GP'S NAME : _____

TO ENABLE MEDICARE ONLINE CLAIMING - PARENT MEDICARE DETAILS REQUIRED:

Account Holder Full Name on Medicare Card: _____

Account Holder Date of Birth: ____/____/____

Account Holder's Medicare Number: _ _ _ _ _ _ _ _ _ _ REF: ()

PATIENT / PARENTAL CONSENT TO COLLECT AND DISCLOSE INFORMATION

The Privacy Act 1988 requires medical practitioners to obtain consent from their patients to collect, use and disclose that patient's personal information.

Collection

We will collect information that is necessary to provide proper advice and treatment for you/your child. Such necessary information may include: full medical history, family medical history, ethnicity, contact details, medicare/private health fund details, genetic information and billing/account details.

This information will normally be collected directly from you and/or your child. There may be occasions when we will need to obtain information from other sources, for example: other medical practitioners such as previous GP's and specialists, other healthcare providers such as physiotherapists, occupational therapists, psychologists, pharmacists, school, nurses or hospitals.

Dr Barker/Dr Samnakay and our practice staff may participate in the collection of this information. In emergency situations we may need to collect personal information from relatives or other sources where we are unable to obtain your prior expressed consent. **We agree to advise our vaccination status.**

Use and Disclosure

With your signed consent, the practice staff will use and disclose your/your child's information for purposes such as: billing, referral to another medical practitioner/health care provider, sending of specimens, referral to a hospital for treatment, the management of our practice, quality assurance, practice accreditation and complaint handling. Your consent also enables us to meet our obligations to our medical defence organisations or insurers, to prevent or lessen a serious threat to an individual's life, health or safety where legally required to do so, such as producing records to court, mandatory reporting of child abuse or notification of diagnosis of certain communicable diseases.

Access

You are entitled to access your own/your child's health records at any time convenient to both yourself and the practice.

Access can be denied when: to provide access would create a serious threat to life or health, there is a legal impediment to access, the access would unreasonably impact on the privacy of another, your request is frivolous, the information relates to anticipated or actual legal proceedings and you would not be entitled to access the information in those proceedings and in the interests of national security.

We ask that, where possible, your request be in writing. We may impose a charge for photocopying or for staff time involved in processing your request. Where you dispute the accuracy of the information we have recorded you are entitled to correct that information. It is our practice policy that we will take all steps to record all of your corrections, and place them with your file but will not erase the original record.

Consent

I have read the above information and I provide my consent for (please circle) Dr Barker/Dr Samnakay and his staff to collect, use and disclose my/my child's personal information as outlined above. This consent is active for all correspondence whether by mail, phone or in person.

I understand that I am entitled to access my/my child's records except where access would be denied as outlined above. I understand that I may withdraw my consent as to use and disclosure of my/my child's personal information (except when legal obligations must be met).

Patient Name: _____

Signed: _____ (Parent/Guardian)

Relationship to patient: _____

IF YOUR CHILD HAS HAD ANY SCANS OR BLOOD TESTS PLEASE ENSURE WE GET A COPY PRIOR TO THE APPOINTMENT. THANK YOU.