SYDNEY
OPHTHALMIC
SPECIALISTS

# PATIENT DETAILS – ADULT

**TITLE:** .....

**FIRST NAME:** ..... **KNOWN AS:** .....

**SURNAME:** .....

**DATE OF BIRTH:** .....

**ADDRESS:** .....

.....**POST CODE:** .....

**MOBILE:** .....

**HOME NUMBER:** .....

**WORK:** .....

**MEDICARE**

**Number:** ☐☐☐☐☐☐☐☐☐☐

**Reference number on card:** ☐ **Expiry:** .....

**HEALTH FUND**

**Name:** .....

**Membership number:** .....

**PENSION CARD**

**Please Circle:** **Aged / Blind / Disability / Single Parent**

**Pension number:** .....

**Expiry date:** .....

**Is your referral from a (please tick):** **GENERAL PRACTITIONER** ☐

**OPTOMETRIST** ☐

**MEDICAL SPECIALIST** ☐

**Please note a referral from a GP or optometrist will last for 12 months, where as a referral from a medical specialist will only last 3 months.*

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# PRIVACY STATEMENT *(All patients to sign)*

**Collection of Personal Information, Privacy Act 1988 (Cth) and HRIP Act 2002 (NSW)**

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 assist, diagnose and treat illnesses and be pro-active in your health care. We will also use the information you provide in the following ways:

- Administrative purposes in running our medical practice. This may include outsourcing dictated medical reports within Australia or offshore.

- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements

- Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice

- Disclosure to other doctors in the practice, locums and by Registrars attached to the practice for the purpose of teaching. Please let us know if you do not want your records accessed for this purpose, and we will note your record accordingly

- Disclosure for research and quality assurance activities to improve individual and community health care and practice management. You will be informed when such activities are being conducted and given the opportunity to opt-out of any involvement

I have read the information above and 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 also aware that this practice has a privacy policy which contains information about accessing and seeking correction of personal information, privacy complaints handling process, and whether the practice is likely to disclose personal information to overseas recipients.

I am aware of my right to access the information collected about me, except in circumstances where access might be legitimately withheld. I understand I will be given an explanation in these circumstances. I understand that if I request access to information about me, the practice will be entitled to charge fees to cover time and administrative costs which may not be covered by a Medicare rebate.

I understand that if my information is to be used for any 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:

These records are stored securely and may be kept for up to seven (7) years following your last consultation. If necessary, for the continuity of your medical care, this information may be shared with other health practitioners involved in your treatment. In certain circumstances there may be a legal obligation to disclose clinical information. A full copy of our privacy policy is available on request.

Parent Signature: _____ Date: _____

Patient's Name: _____