Cardiac Care Associates

PATIENT INFORMATION

**** PLEASE COMPLETE THIS FORM IN FULL & SIGN BELOW****

Personal Information:

SURNAME: (MR / MRS / MISS / MS / DR) .....

CHRISTIAN NAME/S: ..... PREFERRED NAME: .....

ADDRESS: .....

POSTCODE: ..... **OCCUPATION:** .....

TELEPHONE: (H) ..... (W) ..... (M) .....

E-mail: .....

DATE OF BIRTH: .....

Preferred Contact Method (Please tick)**:**

☐ Phone ☐ Email ☐ SMS for appointments

- **MEDICARE NO:** ..... PATIENT NO: ..... EXP DATE: .....
  - ❖ **Pension** Card Number: ..... Expiry Date: .....
- **VETERANS' AFFAIRS (DVA) NO:** ..... Expiry Date: .....
- **HEALTH FUND:** ..... Membership Number: .....

- **YOUR GENERAL PRACTIONER'S DETAILS :** (ie. not your referring specialist)

  Name: .....

  Address / Surgery: .....

- **YOUR NEXT OF KIN:**

  Name: ..... Relationship: .....

  Telephone No: .....

DO YOU GIVE AUTHORITY FOR YOUR NEXT OF KIN TO BE YOUR NOMINATED CONTACT? Yes / No

If **Yes**, please sign and date: Signed-..... Dated - .....

If **No**, please complete section below with your nominated contact details:-

Patient Authority – Nominated Contact (if not your Next of Kin):

I, ...of ..... date of birth..... request, direct & authorize Cardiac Care Associates to speak with ..... (name) ..... (relationship) in the event that I am unable to be contacted, for the purpose of the management of appointments and general accounting. I acknowledge that confidential information about my medical condition will not be passed onto the nominated person without my express authority.

Dated this .....day of .....2011 Signed.....

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 assess, diagnose, treat and be proactive in your health care needs. This means we will use the information you provide in the following way – please see disclosure statement below:-

DISCLOSURE and COLLECTION STATEMENT:

I consent to the disclosure to and collection from medical/specialist practitioners, allied health practitioners and institutions that may require information about my medical history but only to the extent necessary to assess/treat the particular condition that I have consulted the medical/specialist practitioner about. Disclosure and collection may also be required for administrative purposes in running our medical practice including Medicare, DVA and non-medical information for debt collection if applicable.

For administration purposes we may be required to contact you by phone. Do you authorise our staff to:

☐ Identify the name of our medical practice

☐ Leave a message on your answering machine/voice mail

Patient Signature: ..... Date: .....