

# Dr. Rodney S. Allan

Neurosurgeon and Endovascular Neurosurgeon

## Patient Information Sheet

### **PATIENT CONSENT TO COLLECT AND STORE INFORMATION:**

(Please read and sign before completing the rest of the necessary paperwork.)

This practice is bound by the *National Privacy Principles*. These principles set the standards by which we handle personal information collected from patients. As part of our commitment to providing quality health care, personal information is sought from you in order to provide a proper assessment, diagnosis and treatment. Your personal information may therefore be disclosed to other health care professionals involved in your care and your medical file will be handled with the utmost respect to your privacy.

I \_\_\_\_\_ have read the above and agree to collection and storage of my personal information. I authorise Dr Allan to release medical information to the referring doctor, other health professionals involved in my care, solicitors, medical imaging and diagnostic services. In the unlikely event that my account is unpaid, I authorise Dr Allan to release my personal information to a Debt Collection agency or other persons nominated in order to resolve any outstanding balances on my account. I acknowledge that I will be required to pay any associated fees.

I understand that it is my financial responsibility to cover the costs of any consultations I have with Dr Allan. Should surgery be required, I understand that it is my right to have informed financial consent and to be provided with a written quotation should I wish this.

Signed: \_\_\_\_\_

Dated: \_\_\_\_\_

### Personal Information:

(We require a minimum of two telephone contact numbers)

Title: \_\_\_\_\_ Surname: \_\_\_\_\_ Given Names: \_\_\_\_\_

Address: \_\_\_\_\_

Postcode: \_\_\_\_\_ Telephone (H): \_\_\_\_\_ (W): \_\_\_\_\_

Mobile: \_\_\_\_\_ Email: \_\_\_\_\_ Drivers Licence: \_\_\_\_\_

Postal Address: (if different from residential address) \_\_\_\_\_

Sex: ( ) Male ( ) Female Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

Are you an Australian Resident? ( ) Yes ( ) No Country of Birth: \_\_\_\_\_

Person Responsible For Account: ( ) As Above

Title: \_\_\_\_\_ Surname: \_\_\_\_\_ Given Names: \_\_\_\_\_

Address: \_\_\_\_\_

Postcode: \_\_\_\_\_ Telephone (H): \_\_\_\_\_ (W): \_\_\_\_\_

Mobile: \_\_\_\_\_ Email: \_\_\_\_\_ Drivers Licence: \_\_\_\_\_

**PLEASE TURN OVER OR GO TO THE NEXT PAGE**

**Person to Contact (Next of Kin):**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone (H): \_\_\_\_\_ (W): \_\_\_\_\_ Mobile: \_\_\_\_\_

**Referring Doctor:**

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Postcode: \_\_\_\_\_ Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Family Doctor/GP: ( ) as above

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Postcode: \_\_\_\_\_ Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Other Doctors to receive correspondence:**

\_\_\_\_\_

**Medicare/Insurance Details:**

Medicare Card No: \_\_\_\_\_ Ref No: (no. next to your name) \_\_\_\_\_ Expiry Date: \_\_\_\_\_

Pension/Health Care Card No (pl. show card to secretary) \_\_\_\_\_ Exp. Date: \_\_\_\_\_

DVA Number: \_\_\_\_\_ Card Colour: \_\_\_\_\_

Name of Health Fund: \_\_\_\_\_ Level of Cover: \_\_\_\_\_

Membership Number: \_\_\_\_\_ Name of Contributor: \_\_\_\_\_

**Workers Compensation / Third Party** (Please Circle relevant category)

Name of Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_

Postcode: \_\_\_\_\_ Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Claim Number: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

Claims Officer: \_\_\_\_\_

Solicitors Name: \_\_\_\_\_

Address: \_\_\_\_\_

Postcode: \_\_\_\_\_ Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Name of Person Handling Your Claim: \_\_\_\_\_