PATIENT DETAILS AND HEALTH QUESTIONNAIRE

* **YOUR ANSWERS WILL HELP YOUR SPECIALIST PROVIDE YOU WITH THE BEST QUALITY OF CARE.**
* **THE INFORMATION GIVEN IS STRICTLY CONFIDENTIAL AND WILL BECOME A PART OF YOUR MEDICAL RECORD.**

**PERSONAL DETAILS**

LAST NAME ………………………………………………………………… GIVEN NAME/S …………………………………………………………………….

DOB: ………………………………………………………………………….. PHONE …………………………………………………………………………………

ADDRESS ……………………………………………………………………………………………………………………………………………………………………...

EMAIL …………………………………………………………………………………………………………………………………………………………………………..

**MEDICARE OR DVA DETAILS**

CARD NO.……………………………………………………………………………………………………………………………………………………………………..

POSITION ON CARD (IRN)…………………………………………….. EXPIRY DATE…………………………………………………………………………

**HEALTH FUND DETAILS**

FUND NAME ……………………………………………………………….. MEMBER NUMBER……………………………………………………

**EMERGENCY CONTACT**

NAME …………………………………………………………………………………………………………………………………………………………………………..

MOBILE ………………………………………………………………………. HOME PHONE ………………………………………………………………………

**DO YOU SUFFER FROM PROBLEMS AFFECTING ANY OF THE FOLLOWING?**

HEART (e.g. angina, heart attack, congenital or valvular or other cardiac problems YES 🞎 NO 🞎

LUNG (e.g. bronchitis, asthma, COPD or other respiratory problems) YES 🞎 NO 🞎

BRAIN (e.g. stroke, aneurysm) YES 🞎 NO 🞎 LIVER OR KIDNEY YES 🞎 NO 🞎

ABNORMAL BLOOD PRESSURE YES 🞎 NO 🞎 BLEEDING YES 🞎 NO 🞎

DIABETES . YES 🞎 NO 🞎 OSTEOPOROSIS YES 🞎 NO 🞎

ARE YOU A SMOKER YES 🞎 NO 🞎 ALCOHOL YES 🞎 NO 🞎

PREGNANT OR POSSIBLY PREGNANT YES 🞎 NO 🞎 BREAST FEEDING. YES 🞎 NO 🞎

**ALLERGIES** YES 🞎 NO 🞎 If Yes, please list below

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**PLEASE LIST ALL MEDICATIONS USED**

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**ANY OTHER INFORMATION THAT YOU THINK MAY BE USEFUL**

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I agree the above is a true and accurate record. I have answered to the best of my knowledge at the current date.

**PATIENT NAME (OR PERSON RESPONSIBLE)** ………………..……………………………………………………… **DATE** ………………………. **PATIENT SIGNATURE (OR PARENT/GUARDIAN)** ……………………………………………………………………………………………………..

PATIENT CONSENT

We require your consent to collect personal information about you. Please read the following information carefully and sign where indicated below.

The 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 properly diagnose, treat and be proactive in your health care needs.

This means that we will use the information you provide in the following ways

1. Administration purposes in the running of 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. This may occur through referral to other doctors or for medical tests and in the reports or results returned to us following referrals.

I have read the information above and understand the reasons why my information must be collected. I am also aware that the practice has a privacy policy on handling patient information.

I understand that I am not obliged to provide information requested of me, but that my failure to do so might compromise the quality of 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 other purpose other than set out above, my further consent will be obtained.

**Medical photography:** Non-identifying medical photographs may be taken of the patient by the medical team. I consent for these photos and/or video to be used in medical publications, including medical journals, textbooks, electronic publications or presentations.

**Payment:** A signature below signifies that I understand that full payment is required on the day of the appointment.

**INFORMED FINANCIAL CONSENT**

* If there is a fee for surgery, I have been provided with a fee estimate. This fee estimate is for the anticipated procedures that are required for my operation.
* I am aware of my fees and expected out of pocket costs. It is my responsibility to discuss this with my health fund.
* I am responsible for the payment in full of the fee estimate prior to surgery.
* There are various procedures under the Medicare Benefits Schedule that are required as part of this procedure. To minimise my out-of-pocket costs, I understand that OMS SPECIALISTS will invoice my health fund or Medicare directly for these procedures. I have the right to request an itemised invoice for these procedures.
* Due to the unpredictable nature of surgery, products may be required to achieve the optimal outcome. If prior knowledge of any required products exists, I will be informed prior to surgery.
* If any products are required during surgery the hospital team will use products required to achieve the optimal outcome, according to the best knowledge and evidence at the time. Costs of these products will be invoiced to my health fund if the health fund covers the use of these products; or to myself if I am not covered by the health fund for the use of these products.
* I am free to discuss any anaesthetic costs directly with the anaesthetist. I am free to discuss any hospital costs directly with the hospital.

**Patient name** ………………………………………………………………………………………………………………………………………

**Patient signature** ………………………………………………………………………………… **Date .**………………………………..

**Parent or Guardian’s name and signature (if applicable) .**……………………………………………………………………