Patient Information

To assist us with your treatment, please complete this form.

Patient Details

Title: First Name: Initial: Surname:

Address: Street:

Suburb: State: Postcode:

DOB: DD / MM / YYYY Email: @ Occupation:

Phone Numbers: Home: Work: Mobile:

☐ *Check box if you do not wish to receive SMS reminders of your appointments.*

Next of Kin: Relationship:

Phone: Home: Work: Mobile:

Referring Doctor

Referring Doctor's Name: Date of Referral:

Address: Phone:

General Practitioner: *(if different from above)*

Address: Phone:

Health Insurance

Medicare Card No: No. Left of Name: Expiry: MM / YY

Do You Have Private Health Insurance: ☐ Yes ☐ No Name of Health Fund:

Membership No: No. Next to Name: *(if applicable)*

Type of Coverage: Hospital & Extras / Hospital Only / Extras Only Any Exclusions:

Do You Hold a DVA Card: ☐ Yes ☐ No DVA No: Colour of Card:

Is This A WorkCover Claim: ☐ Yes ☐ No Date of Injury/Accident: DD/MM/YYYY Date of Claim: DD/MM/YYYY

Claim No: Case Manager: *(if known)* Phone: *(if known)*

Insurance Company's Name: Phone:

Employer's Name: Phone:

Address:

Sunshine Coast Neurosurgery ensures all measures are taken to protect the patient's privacy. In the event that we need to contact you, we will contact you on the above listed contact numbers. Should you have an answering service attached to the above contact number/s or if another member of your household answers, please indicate if you consent to Sunshine Coast Neurosurgery leaving a message for you.

☐ CONSENT ☐ DO NOT CONSENT

Your Privacy, Our Concern - Consent to Use Your Personal Information

Sunshine Coast Neurosurgery complies with the Commonwealth Privacy Act and all other state and territory legislative requirements in relation to the management of personal information. We collect information that is necessary for the provision of your health care. Personal information obtained from you in your consultation may be used to provide information to various health services involved in supporting your health care management (e.g. pathology, radiology, hospitals or other specialists).

I have read and understood The Sunshine Coast Neurosurgery Privacy Policy and understand my rights and responsibilities.

I ______________________ hereby consent to my personal information being released as and when required.

(Patient/Guardian/POA)

Signature of Patient/Guardian/POA: Date: DD / MM / 20YY