Heart of Australia Pty Ltd
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PATIENT INFORMATION FORM

PATIENT DETAILS

Title: _____ **Given Name:** _____ **Surname:** _____

Sex (please circle): Male / Female **Date of Birth:** ____/____/____

Ethnicity: ☐ Aboriginal ☐ Torres Strait Islander ☐ Caucasian ☐ Other (please specify) _____

Is wheelchair access required? (Please circle): Yes / No

Occupation: _____ **Job title:** _____

CONTACT DETAILS

Home phone: _____ **Mobile:** _____ **Work:** _____

What is your preferred number for contact? ☐ Home ☐ Mobile ☐ Work

Which method of contact do you prefer for appointments/reminders? ☐ SMS ☐ Phone

Email: _____

(By providing my email above, I consent to use email and I acknowledge emails may disclose personal information and is not a secure form of communication as emails are not encrypted during transmission. By providing consent to release medical records via email is at my discretion and Heart of Australia assumes no responsibility or liability for an interception.)

Residential address: _____

Postal address (if different from above): _____

MEDICAL DETAILS

Medicare number: _____ **Reference number:** _____ **Expiry:** ____/____

Veteran Affairs card number: _____ **Card type:** ☐ Gold ☐ Silver ☐ White

Pension number: _____ **Pension type:** _____

Private Health Fund: _____ **Member number:** _____

GP DETAILS

GP name: _____ **GP practice name:** _____

Practice address: _____

EMERGENCY CONTACT DETAILS OR PARENT/GUARDIAN (if patient is a minor)

Full name: _____ **Relationship to patient:** _____

Home phone: _____ **Mobile:** _____ **Work:** _____

INFORMATION DISCLOSURE

Can we leave messages for you identifying the practice as the caller? ☐ Yes ☐ No

I authorise the following person to take messages regarding an appointment/reminder/change of appointment details / clinical details relating to my healthcare *(if you do not nominate someone below, we will only be able to speak with you regarding the above):*

Name: _____ **Relationship:** _____ **Phone:** _____

PATIENT CONSENT

I authorise the release of my medical records from existing and past health care providers to my treating doctor for my current care and future treatment.

If your account is to be billed directly to a third party or Medicare and for any reason the claim is rejected the account will be reissued as an invoice, and you will be responsible for any outstanding amount.

Date: ____/____/____ **Signature:** _____

Privacy Notes: This information is required to enable us to accurately maintain our records and to ensure that patients are correctly billed. The authorisation will allow us to access your previous medical records needed to assist with your assessment and treatment. Phone numbers will be used to confirm appointments. If you have any concerns regarding this, please discuss them with the treating doctor during your consultation.