DR KATHRYN WIGGINS

MBBS (HONS) FRACP PHD PROVIDER NO. 227192QB

NEPHROLOGIST

Main Rooms: Suite 2A, 330 High Street, Ashburton VIC 3147
Ph: (03) 9885 8100 Fax: (03) 9885 6495
Consulting at Ashburton, Brighton and Elsternwick
medical correspondence: argusreports@cpdesmond.com.au
email: admin@cpdesmond.com.au

PATIENT INFORMATION SHEET

NAME:.....

ADDRESS:.....

.....

PH (H).....**(WK)**.....**(M)**.....

DATE OF BIRTH:.....**AGE**.....

EMAIL ADDRESS:.....

EMERGENCY CONTACT:.....**PH:**.....

ACCOUNT: (PLEASE CIRCLE) SELF TAC WORKCOVER

TAC/WORKCOVER: Claim No:.....**Contact Person:**.....

MEDICARE NO:.....**REF NO:**.....**EXP:**.....

PRIVATE HEALTH.....**M/SHIP NO:**.....
Level of Cover: (Please Circle) Gold Silver Bronze Basic

USUAL GP:(If not referring Dr).....

GP CLINC:.....

PENSIONER: YES/NO.....**TYPE**.....**PEN NO:**.....

DRUG ALLERGIES:.....

PLEASE TURN OVER TO READ AND SIGN OUR PRIVACY POLICY.

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

This medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your persona details and 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 inthe following ways:

1. Administrative purposes in running 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 the referrals.

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

I undertstand that I am not obliged to provide any information requested of me but that my failure to do so may compromise the quality of the 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 withheld. I understand that I will be given an explanation in these circumstances.

I understand that if my informations is to be used for any other purpose other than set out above my further consent will be obtained.

I consent to the handling of my information by this proactice for the purposes set out above, subject to any limitations on access or disclosure of which I may notify this practice.

SIGNED:.....DATE:.....

PATIENT NAME:.....
(IF UNDER THE AGE OF 18, A PARENT OR LEGAL GUARDIAN SHOULD SIGN)

ACCOUNT HOLDER(if patient under 18):.....

ADDRESS:.....

DATE OF BIRTH:.....M/CARE No:.....