PATIENT DETAILS FORM – DR VINNY MAMO

SURNAME: …… MR / MRS / MISS / MST / MS

GIVEN NAMES: ……..……..……..

POSTAL ADDRESS:……..……

……..POSTCODE:……..…

TELEPHONE: Home:.. …… Work:..…..……Mobile : …….

DATE OF BIRTH: …….. SMS APPT REMINDER : YES/NO

EMAIL : @ ……

FAMILY DOCTOR: …….

REFERRING DOCTOR: ……

NAME OF TREATING PHYSIOTHERAPIST:…….

MEDICARE NO: …… POSITION ON CARD……EXPIRY DATE… /….

ARE YOU IN A PRIVATE HEALTH FUND? YES / NO

(If yes) NAME OF FUND: ……..MEMBERSHIP NO:……..……

VETERANS AFFAIRS GOLD CARD NO: …….

ARE YOU AN AGED PENSION CARD HOLDER? YES / NO

EMERGENCY
CONTACT …….....

TELEPHONE: (H) ……(M) ……..…….

If the patient is a child under 18 years, please provide details of person responsible for this account.

NAME: ……..DOB: ……

MEDICARE NO: ……POSITION ON CARD:……EXP DATE …../…..

ADDRESS: ……..

WORKERS' COMPENSATION DETAILS (if applicable)

NAME OF EMPLOYER: ……..…

ADDRESS OF EMPLOYER: ……..…

…….. POSTCODE:….. …….

EMPLOYER'S PHONE NO: ……

NAME OF INSURANCE COMPANY: ……..

ADDRESS: ……. POSTCODE: …….

HAS A CLAIM BEEN LODGED: YES / NO (If yes) CLAIM NO: ……..…….

DATE OF INJURY: …….

Hip, Knee & Shoulder Replacement & Arthroscopy

Dr. Vinny J. Mamo
M.B.B.S., F.R.A.C.S., F.A.ORTH.A.
Orthopaedic Surgeon

Provider No: 060218EY

30 Docker St
PO Box 5013
WAGGA WAGGA NSW 2650
Ph: (02) 69263088
Fx: (02) 69255560

PRIVACY INFORMATION AND CONSENT FORM

The law gives you certain privacy rights in relation to information that you give to this Medical Practice. We need your consent to collect personal information about you. The fact that you have come here implies that you consent to us knowing about your health situation either for a particular event or generally. This form explains what your rights are over the use we make of the information and how we may disclose it to other medical service providers.

The main reason we collect information from you is so we can assess, diagnose and treat your illness properly and be pro-active in your health care. We will also use the information you provide in the following ways:

* Administration of this medical practice

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* Billing, including compliance with Medicare and Health Insurance Commission requirements.

* Disclosure to others involved in your health care, including doctors and specialists outside this Practice who may become involved in treating you. This may occur through referral to other doctors, or for medical tests and in reports or results returned to us following the referrals. If necessary, we will discuss this with you.
  Disclosure to others for medical defence purposes if necessary.

* Copies of patient's x-rays, MRI's and other medical imaging, patient's photographs or other visual images may be used for education and research purposes, eg. teaching of medical students, doctors and allied health professionals.

PATIENT'S ACKNOWLEDGEMENT:

I have read this form and understand why collecting information about me is necessary. I am also aware that this Practice has a privacy policy on handling patient information.

I understand that I am not obliged to provide any information requested of me. I also understand that failure to provide this Medical Practice with all the information it needs may restrict the Practice's ability to provide the quality of health care and treatment that I want.

I am aware that I have the 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 consent to the handling of my information by this Practice for the purposes set out above, subject to any limitations on access or disclosure about which I notify this Practice now or at any future time.

I acknowledge that I have read this form before signing it.

Signed: ……Date:……..