PATIENT INFORMATION
PLEASE COMPLETE, SIGN WHERE APPLICABLE AND BRING TO YOUR APPOINTMENT

Title:……..First Name:……Middle Name:……

Surname: ……..……..Known as: ……

Postal Address: ……

Suburb/Town: ……

State: …… Post Code: ……. DOB: ……/……../……..

Home Phone No: …… Work Phone No……

Mob: ……. Email address: ……...

Referring Doctor (GP): ……..

Pension/Health Care Card No……..Exp. Date……/……..

Medicare Card No.: ……Ref. No.(The No. next to your name) …. Exp. Date ……/....

Private Health Fund: NO/YES: (which Fund)……..Member No: ……

DVA (Veteran) No: ……. (If applicable)

ALLERGIES TO MEDICATION: Nil known/YES: ……

PATIENT AUTHORITY — NOMINATED CONTACT

I……Request, direct and authorize Dr. Hempenstall or his employees to speak with…(Full Name of Nominated Person)

……..Relationship…… Contact Phone

Number…… In the event that I am unable to be contacted, for the purpose of

Managing appointments and any issues related to hospital bookings, x-ray or pathology bookings,

I acknowledge that I have consented for confidential information & my medical condition will only be passed on to the above

nominated person.

Dated ……. /……. /…….. Signed……

PLEASE COMPLETE THIS FORM AND BRING TO YOUR APPOINTMENT

Toowoomba Specialist Centre
Suite 14, 9 Scott Street, Toowoomba Q 4350
Ph.: 4632 8481 Fax: 4632 8353

PATIENT CONSENT — DR. J.A. HEMPENSTALL

PATIENT Name: …….. DOB: ……..

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 personal details and a 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 in the following ways:

- *Billing purposes, including compliance with Medicare and Health Insurance Commission, Workers Compensation and Insurance requirements.*
- *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.*
- *Administrative purposes in running our medical practice including non-medical information for debt collection if applicable.*

I have read the information above and understand the reasons why my information must be collected. 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, but that my failure to do so might 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 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.

I consent to the handling of my information by this Practice for the purpose set out above, subject to any limitations on access or disclosure that I notify this Practice of.

Signed …… Dated ……

PLEASE COMPLETE IF THERE IS A THIRD PARTY ***YOU DO NOT WISH*** INFORMATION TO BE GIVEN TO

Irrespective of any request received, I direct you **Not** to provide my personal information to

(please specify name/details): ……..

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