DR SUYOG KULKARNI
DNB, FRACS,FaorthA,CIME
ORTHOPAEDIC SURGEON
PROV NO. 250527KY

PATIENT DETAILS FORM

Title: _____ **First Name:** _____ **Surname:** _____

Address: _____

Suburb: _____ **State:** _____ **Postcode:** _____

Date of birth: _____

Home Phone: _____ **Work Phone:** _____ **Mobile:** _____

Email Address: _____

Do you consent to receive appointment reminders via SMS? Yes / No

Medicare No.: _____ **Reference No.:** _____ **Expiry Date:** _____

Private Health Fund: _____ **Membership No.:** _____ **Reference No.:** _____

DVA Card No.: _____ **DVA Card Colour:** _____ **DVA disability:** _____

HCC / Pension No: _____ **Expiry Date:** _____

Referring Doctor: _____ **Date on referral:** _____

Usual GP (if different from above): _____

Emergency contact

Name:_____**Phone:**_____

Workcover Claim No.-_____

Employer - _____

Suburb -

CONSENT TO COLLECT PATIENT INFORMATION

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 medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. We will use the information you provide in the 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 as advised by you.

I understand the reasons why my information must be collected.
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 purpose other than the above, my consent will be sought.

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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 of which I may notify this practice.

Signed: _____ **Date:** _____

Patient Name (Please print) _____