PATIENT INFORMATION SHEET
DR TERRY HAMMOND

Today's Date: _____

Surname: _____ MR ☐ MRS ☐ MISS ☐ DR ☐

Given Names: _____ Preferred Name: _____

Address: _____

_____ Postcode: _____

Date of Birth: _____ Age: _____

Home Phone: _____ Work Phone: _____ Mobile: _____

Email Address: _____

Can we contact you or leave a message at the above phone numbers: YES ☐ NO ☐

Medicare Number: _____ Ref Number: _____ Expiry: _____
(The Reference number is the NUMBER BESIDE YOUR NAME on your Medicare card)

Are You on a Pension? YES ☐ NO ☐ Aged: ☐ Disability: ☐ Health Care: ☐

Pension/Health Care Card Number: _____ Expiry: _____

DVA: YES ☐ NO ☐ Gold Card: ☐ File Number: _____

Occupation: _____

Name of Private Health Fund: _____ Longer than 12 mths _____

Full Hospital Cover YES ☐ NO ☐ Private Fund Membership No: _____ Ref Number: _____
(The Reference number is the NUMBER BESIDE YOUR NAME on your Health Fund card)

(**PERSON TO CALL POST SURGERY**)
_____ Relationship: _____

Contact No: _____

Do you have a Physiotherapist Y ☐ N ☐ Name: _____

Name of General Practitioner: _____

Previous Serious Illness? _____

Previous Operations? _____

Current Medications? _____

Past Thrombosis/Clots? _____ When? _____

Issues Relevant To You Having Surgery: _____

Allergies: _____

Please complete overleaf…..

Visit Related to Worker's Compensation QLD? YES ☐ NO ☐ Claim No:_____

If not Work Cover QLD please specify Name and Address of Insurer:

_____

Claim No: _____

Briefly, how did the injury occur : _____

Is your visit related to other Insurance Claim? YES ☐ NO ☐ Claim No: _____

Insurer/Solicitors Name: _____

Address of Insurer: _____

Case Manager _____ Contact _____

YOUR FEEDBACK IS APPRECIATED. Please take the time to assist us.

Please let us know who suggested you be seen by Dr Hammond

- ☐ GP recommendation
- ☐ Requested GP to refer to Dr Hammond
- ☐ Physiotherapist
- ☐ Friend
- ☐ Dr Hammond Website
- ☐ Yellow Pages

Your appointment Tick if Any Concerns?

- ☐ Making appointment
- ☐ Locating rooms
- ☐ Parking

Have you seen Dr Hammond's Website? ☐Yes ☐No

- ☐ Excellent
- ☐ Good
- ☐ Average
- ☐ Fair

PRIVACY POLICY Dr Terry Hammond MBBS FRACS Orth

Under the Privacy Amendment Act 2000 it is important that Medical Practitioners explain to patients how their practice functions and your rights as to the data collected. I am a health provider in the private sector, bound by the Act's National Privacy Principles. A copy of the Principles can be given to you on request.

As part of our commitment to your care, we require your consent to obtain the following information:

a. Personal details such as name, address, date of birth, telephone number, next of kin, Medicare number and insurance details. This information is recorded in a file and also on computer.
b. Your medical history, as well as your current medications, pathology and radiology reports, and results of relevant physical examinations. This information is kept in your medical records.
c. All correspondence from your health providers such as referral letters, pathology results, radiology results, etc., which are placed with clinical notes in your file. Photographs will not be shown to others without your consent.

The information stored on computer includes your personal details, outgoing letters, accounts and appointments. This data is accessed by a secure password known only by my staff. The charts are readily accessible by staff but when the rooms are unattended, the office is locked securely. The only persons who have access to your information are staff and myself. Another practitioner would have access in an emergency only.

A summary of information collected, advice concerning your treatment and a copy of relevant pathology and radiology reports will be forwarded to your referring doctor unless you expressly request this not to happen.

Except where the law requires disclosure (as in the case of a subpoena, for instance), we will only release any other personal information to relatives or other third parties if we have your written authority. Information relevant to billing and debt recovery may have to be disclosed without your authority.

TYPE NAME AS SIGNATURE_____ DATE_____