Dr Gerard Bayley

PATIENT DETAIL & CONSENT FORM - Please complete all details to the best of your knowledge. The information requested on this form is a requirement for treatment at this practice.

MR/MRS/MISS/MS/DR/OTHER	Surname:	
Given Name(s):	Preferred Name:	
Home Address:		
Postal Address:		
Date of Birth:	Occupation:	
Home Ph:	Work Ph:	
Mobile:	Email:	
Next of Kin:	NOK Relationship:	
Next of Kin Phone No(s):		
Medicare No:	Ref No:	Expiry:
Health Fund Name:	Member No:	
Level of Cover:	Excess amount $:	
DVA Number:	Type: Gold / White	
Concession Card: YES / NO	Type: Aged / Disability / Healthcare	Number:
Local Doctor:	Location:	

Person responsible for account (if not yourself):

Name:	Date of Birth:
Address:	Phone:

HEALTH INFORMATION

Current Medical Conditions:		
Heart Condition: YES / NO	Lung Condition: YES / NO	
Past Medical Conditions:		
Current Medication: Aspirin / Warfarin / Anti-inflammatories / Plavix / Isocover/ Fish or Krill Oil / Health Supplements		
Other:		
Drug Allergies:	Other Allergies:	
Smoking: Past / Present / Never	Hepatitis B: YES / NO	HIV: YES / NO
Contact with Cruetzfield-Jacob (Mad Cow) Disease: YES / NO		

VACCINATION STATUS

Have you been vaccinated against Covid-19? YES / NO

Number of Vaccines: ___________

****Please note: Dr Bayley endeavours to run on time to scheduled appointments. Unfortunately, this is sometimes out of our control and your appointment may run later than the scheduled time. We ask for your patience and understanding.**

PRIVACY INFORMATION AND CONSENT

The Privacy Act 1998 gives you certain privacy rights in relation to the information you give this medical practice. We require your consent to collect personal information about you. Your presence here implies you consent to us knowing about your health situation for this presentation and holistic care. This form explains what your rights are over the use we make of the information and how we disclose it to other medical service providers. We acknowledge the information we ask may be deeply personal, but not having it will restrict our capacity to provide you with the standard of medical care you expect.

Please read the following carefully then sign where indicated below. This form will go on your file and you may examine or change it at any time.

This medical practice collects information for the primary purpose of providing quality health care. We require your personal details and full medical history to properly assess diagnose and treat your medical conditions. The information will also be used in the following ways:

1. Administration of this medical practice.
2. Billing, including compliance with Medicare and Health Insurance Commission requirements.
3. Disclosure to others involved with your health care, including treating doctors outside this practice. This may involve referral to other specialists, anaesthetists and pathologists.
4. Disclosure to others for medical defence purposes if necessary.
5. Disclosure to Locums when attached to this practice for the purpose of continuing patient care.
6. Disclosure to Registrars in a de-identified form for specific or educational purposes. This includes photographic material and test results.
7. Disclosure for research and quality assurance activities to improve individual and community health care and practice management.

PATIENT CONSENT:

I have read this form and understand why collecting information about me is necessary. I am also aware 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 I want.

I am aware I have the right to access the information collected about me, except in certain circumstances where access may be legitimately withheld, I understand I will be given an explanation in these circumstances.

I understand that if my information is to be used for any purposes other than set out above, my further consent will be sought.

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 in the future.

I acknowledge I have read this form prior to signing and that a staff member has at my request clarified any aspect of it I did not first understand.

Signed: ____ Date: ____________________________