SYDNEY **EAR NOSE & THROAT** CLINIC

PATIENT INFORMATION

Title ___ First Name_____________________________ Surname _____________________________

Known as _____________________________ DOB _____________________________

Home Phone _____________________________ Work Phone _____________________________

Mobile _____________________________ Email _____________________________

Physical Address ____

____

Postal Address ____

(If different from above) ____

Emergency Contact
Name: ____________________ Relationship to you: ____________________

Contact number: ____________________ Contact DOB (if patient <12yro):

GP: Name & address ____

Referring Doctor ____

(If different from above)

Medicare No.__ __ __ __-__ __ __ __ __-__ Reference on card (number next to your name)____

Health Fund ____________________ Membership number ____________________________

Have you been admitted to hospital in the last twelve months? ☐ Yes ☐ No

Should we contribute your medical information to www.MyHealthRecord.gov.au? ☐ Yes ☐ No

PERMISSION TO COLLECT AND STORE INFORMATION

We need to collect and store some information about you:
To help us provide good and safe treatment and to provide Government bodies with information to which they are legally entitled. These records will contain information including, but not limited to, your name, address, date of birth, Medicare number, referring doctor's details and clinical imaging and records. Your medical information is also used, in an unidentifiable way, for auditing, research and education purposes.

We undertake only to collect information which is appropriate to your total care and to only use the information for its intended purpose. Your medical records are stored securely and can only be accessed by authorised staff. We are required to keep your records for up to seven years following your last consultation. If necessary, for the continuity of your medical care, this information may be shared with other health practitioners involved in your treatment. In certain circumstances there may be a legal obligation to disclose clinical information, for example to Government bodies. A full copy of our privacy policy is available on request.

I have read the above explanation and agree to the collection and storage of information.

Signed .... Dated ....

Relationship to patient (where necessary, eg. parent) ....