Promedical NSW

Dr Charlie Lin - Orthopaedic Surgeon

Hip & Knee Reconstruction, Replacement & Trauma

Patient Information & Consent Form

Title (Please circle)	**Mr**	**Mrs**	**Ms**	**Miss**	**Dr**	**Mstr**
Surname						
First Name	**Middle Initial (if applicable)**			**Preferred Name**		
Street Address						
Suburb				**State**		
Postcode:						
Postal Address (if different from street address):						
Mobile Phone			**Work Phone**			
Email Address			**Home Phone**			
Date Of Birth						
Medicare Number			**Ref #**	**Expiry Date**		
Private Health Fund				**Member #**		
DVA Number				**DVA Card Colour**		
HCC/Pension Number				**Expiry**		

Do you consent to SMS reminders? **Yes / No**

How did you hear about Dr Lin?: (Please Circle)

Usual GP SAN Emergency Hornsby Emergency Friend Internet Search

Other (please specify)_____

Referring Doctor _____ Phone _____

Address _____

_____

Usual GP (If other than above) _____ Phone _____

Address _____

_____

Please see over

Name: _____

Workers Compensation/Third Party details (If applicable)

Employer Name _____

Address _____

_____

Employer phone _____

Insurance Company Name _____

Address _____

_____

Contact person _____ Phone _____

Date of Injury _____ Claim # _____

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.
- 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.

Signature of Patient: ……..….

Print name and signature of Parent /Guardian (if under 18): ……..….

We take your privacy seriously. Please ask us for a copy of our privacy policy