Dr Neil Ferguson
ORTHOPAEDIC SURGEON
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ABN: 339 969 414 56
Provider No: 460513FT

NEW ENGLAND HIP AND KNEE

Patient Information Form

Title: Mr / Mrs / Ms / Miss / Dr / Other: _____

Surname: _____ **Given Names:**_____

Date of Birth: ____ /____ /____ **Gender:** Female □ Male □ Other □ _____

Do you identify as Aboriginal or Torres Strait Islander: No □ Yes Aboriginal □ Yes Torres Strait Islander □ Both □

Address: _____

_____

Postal Address: _____

Phone Home: _____ **Mobile:** _____

Email: _____**Occupation:**_____

Emergency Contact: _____ **Mobile:** _____

Relationship: _____
(May be contacted for the following reasons: When unable to contact patient regarding urgent enquiries, appointments, for billing purposes or in the case of an emergency.)

Medicare No: _____ **Patient Ref. No:** _____ **Expiry Date:**____ /____ /____

Health Fund: _____ **Member No:** _____

Are you covered for Hospital: Y / N **Level of cover:** (e.g. Bronze, Silver, Silver +, Gold)_____

Have you had this level of cover for more than 12 months? Y / N

DVA No: _____**DVA Card Colour:** _____**Conditions**_____

Referring GP: _____

Regular GP: _____
(If Different from Referring GP)

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 can 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 failure to do so may compromise the quality of the health care and treatment given to me.
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.

Print Name:_____ Signature:_____ Date: ___ /___ /___