LEADING FACE SURGERY

CONFIDENTIAL

SURNAME: Mr/Mrs/Ms/Miss/Dr .....

GIVEN NAMES: .....

DATE OF BIRTH: .....

ADDRESS: .....

.....POST CODE: .....

TELEPHONE: Home:.....Work:.....Mobile:.....

Would you like us to remind you of any future appointments via SMS? YES / NO

OCCUPATION: .....

EMERGENCY CONTACT: Name: .....Telephone: .....

MEDICAL PRACTITIONER: .....

Please indicate if you have, or have had any of the following:

		DETAILS
Heart disease/problems	YES / NO	
Blood pressure problems	YES / NO	
Excessive bleeding	YES / NO	
Asthma/bronchitis	YES / NO	
Hepatitis	YES / NO	
Diabetes	YES / NO	
Reflux	YES / NO	
Epilepsy	YES / NO	
Allergies	YES / NO	
Operations	YES / NO	
Osteoporosis or other bone disease	YES / NO	
Any other serious diseases or illnesses	YES / NO	
Are you taking any tablets or medication?	YES / NO	
Have you ever been in hospital?	YES / NO	
Ladies, are you pregnant?	YES / NO	

Have you had any previous cosmetic procedures? YES / NO

If yes, detail

(1) Surgery: .....
(2) Injections (eg muscle relaxants): .....
(3) Fillers (eg dermal fillers): .....
(4) Other : .....

HEALTH FUND: .....Membership No: .....Ref No:.....

MEDICARE NUMBER: .....Exp Date: .....Ref No:.....

Name and address of person responsible for payment of accounts (if different from above):

.....

I understand that payment of the account(s) is my responsibility, and that my health fund (if any) will not fully cover the amount. I undertake to pay any further expenses incurred by a Collection Agency resulting from my non payment of overdue accounts. I have had the opportunity to read the practice's Privacy Policy.

SIGNATURE: ..... DATE: .....

If you have any questions, please ask the nurse or the receptionist. Thank you.

LEADING FACE SURGERY

PRIVACY POLICY

At Leading Face Surgery we aim to provide you with the best possible care. We appreciate your co-operation and understand that information provided to us is highly personal and needs special care and protection. This practice is committed to protecting your privacy in accordance with the National Privacy Principles. This obligation rests not only with the Doctors but all members of staff who have access to this information.

COLLECTION OF INFORMATION:

Staff members will record the following information in your file:

- Full name, date of birth, addresses and phone numbers – to allow correct identification of files, appointments and questions, and to enable us to contact you when necessary.
- Medicare number/Health Fund details – necessary for account purposes and hospital bookings.
- Pensioner, Veterans or Health Care Card details – to enable you to claim appropriate concessions.
- Medical details – allergies, past history, medications.
- Referring Doctor's, Dentist name and address – to enable us to communicate with your referring Doctor, and for you to obtain your Medicare rebate.
- Medical photo's – I acknowledge that as a normal part of some procedure(s)/treatment clinical photographs and/or video recordings may be taken of me to form part of my clinical record. I understand that these clinical photographs and/or videos will, as part of my clinical record, be kept confidential unless at a later time I give permission in writing for them to be included in published documents and/or to be used as educational material.

If you are unable to provide us with the above information we would have genuine concerns that we could not offer you the best standard of care.

STORAGE AND DISPOSAL OF INFORMATION:

Paper files are stored in a secure medical records area. Only authorized personnel may access these files. Information is also stored on our computer system which can only be accessed using a secure password. Obsolete information is destroyed with your identity protected.

DISCLOSURE OF INFORMATION:

Dr Yelegin will write to your referring Doctor/Dentist, summarizing the findings and recommendations from your consultation. Copies of this letter may be sent to other Doctor's involved in your case to ensure they are informed of your condition.

Your information may be related to other health providers if deemed to be in your best interest. Occasionally we are obliged by law to release details relating to statutory requirements or public health matters – this information is kept strictly confidential.

In all other circumstances your written consent is required before we disclose information to a third party. Upon your request, your records will readily be made directly available to any Doctor who needs them to provide a second opinion to establish your cardiac status.

SIGNED CONSENT:

I consent to the handling of my information by this practice for the purposes and in the manner set out above, subject to any limitations on access or disclosure that I notify this practice of:

Signature of patient ..... Date: .....

Please print full name: .....

If you wish to discuss any matters related to your personal information and medical records, please do not hesitate to let our staff know so that appropriate arrangements can be made.