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Dr Marcus Chia
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PATIENT INFORMATION SHEET

Mr/Mrs/Miss/Ms/Dr -select-

Given Names:________________________ Surname:______________________________

Address:______________________________________DOB:_____/_____/__________

____Postcode:________________

Phone H:__________________ W:___________________M:_____________________

Email: _____________________________ Occupation: ________________________

Emergency contact:__________________Relationship:_____________Phone:___________

Medicare No:__________________________ Position on card :________Valid to :________

Private fund:___________________________ Membership No:______________________

HCC/Pension/DVA -select- Card Number : ____________________Expiry: _______

Account to (if child)__________________________________Parent DOB:_____________

Parent Medicare No:_________________________ Position on card :_____Valid to:_______

General Practitioner:_______________________________ Phone:___________________

Address:____ Postcode:__________

Physiotherapist:__________________________________ Phone:___________________

Address:____ Postcode:__________

How did you hear about Dr Chia? -select-

Other (please specify):____

WorkCover/CTP- Type of injury:__________________ Date of injury:______________

Insurance company:______________________________ Claim No:________________

Case Manager:___________________________________ Phone:__________________

Employer:_______________________________________ Phone: __________________

Address:____ Postcode:__________

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:

- Administrative purposes in running our medical practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice as advised by you.
- Research and teaching purposes (all information, medical imaging and clinical photography used will be de-identified)

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