PATIENT DETAIL FORM OBSTETRICS

ROD ALLEN
OBSTETRICIAN & GYNAECOLOGIST

Dr Rod Allen abides by the Privacy Act 1988. Information supplied by you is kept strictly private and confidential and will assisst in providing the best possible care for you. Please complete ALL sections below.

YOUR DETAILS

last name | first name | title

preferred name

address

date of birth | occupation

home phone | work phone

mobile | email

partner's name | partner's mobile

HEALTH INSURANCE DETAILS

medicare no. | ref | expiry

private health fund | membership no.

REFERRAL DETAIL

referring doctor | usual GP

MEDICAL DETAILS [PLEASE complete all sections. Ask our staff for help]

list of any medical problems or conditions

list of current medication you are taking

list of your past surgery

are you allergic to any medications? NO ◯ YES ◯

if yes, pls specifiy

list all past pregnancies

Do you smoke? NO ◯ YES ◯

Do you drink alcohol? NO ◯ YES ◯

When was your last Pap smear?

FAMILY HISTORY

Is there any history of congenital abnormalities in either your or your partner's family? NO ◯ YES ◯

In your family is there any history of bleeding or clotting disorders? NO ◯ YES ◯

major pregnancy complications? NO ◯ YES ◯

SIGNATURE | DATE

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PRIVACY

All private medical practitioners are required to comply with the National Privacy Act. Consequently your consent is required to collect personal information about you. Please read this information carefully and sign where indicated at the end of this document.

The provision of quality health care is Dr Allen's primary concern. This requires a doctor - patient relationship of trust and confidentiality. A patient's personal information is handled in accordance with this practice's privacy policy and consistent with privacy legislation. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. A failure to provide accurate information may compromise the quality of the health care provided. We will use the information you provide in the following ways:

- Administrative purposes in running this medical practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements
- Disclosure to others involved in your health care, including referring doctors, (your GP) and other treating doctors, specialists, or allied health professionals (e.g. physiotherapists) outside this medical practice.
- To access past and future pathology results and medical imaging reports
- So Dr Allen can access and upload to your PCEHR (Patient Controlled Electronic Health Record)

It is Dr Rod Allen's practice and desire to discuss the nature of a patient's treatment and in particular test results openly and honestly with the patient. Should you require that they also discuss such information with a close relative or friend, you should inform Dr Allen of such details. Likewise if there are details you would prefer kept confidential between you and Dr Allen and not shared with your partner or next of kin please inform Dr Allen.

CONSENT TO RELEASE OF MEDICAL INFORMATION

- I give my consent to Dr Rod Allen or his employees to contact medical practitioners or others I have consulted to gather any information relevant to my care.
- I authorise those practitioners or others referred to above to release such information to Dr Allen or his employees as requested.

FINANCIAL

- I understand that payment of the account, in full, is my responsibility and that my health fund might not cover the total amount invoiced.
- I am responsible for any other costs that might be incurred resulting from my not paying my account in full, by the due date.

OTHER

- I give permission for Dr Rod Allen or his employees to contact me via SMS re e.g. appointments.
- I understand it is my responsibility to contact Dr Allen's rooms for results
- When sending photographs of me or my child to Dr Rod Allen I give permission for these photos to be used online on our website or on display in our rooms.

I have read and understood the information above.

SIGNATURE

DATE

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PRINT SUBMIT