DR JACQUELINE McMASTER'S CLINIC - CONFIDENTIAL

Patient Details Form – Please complete all pages

Surname: _____ First Name: _____ Title: Dr Mr Mrs Miss Ms

Address: _____

_____ Postcode: _____

Phone No. Home: _____ Work: _____ Mobile: _____

Email Address: _____

Date of Birth: _____ Age: _____ Weight: _____ kg

Medicare No.: _____ Exp.: _____ DVA No.: _____

Health Fund: _____ Membership No.: _____

Occupation: _____ Pension: _____ Pension No.: _____

Referring Doctor: _____ Provider No.: _____

Address: _____

_____ _____ Phone No.: _____

GP: _____

Address: _____

_____ Phone No.: _____

Reason for referral: _____

Worker's Compensation,Third Party or other compensable injury.

Claim No.: _____ Date of Injury: _____

Insurance Company: _____ Case Manager: _____

Postal Address: _____

_____

Medical History

Do you suffer from any of the following medical problems:

Cardiac

High blood pressure	☐	Angina	☐	Irregular heart beat	☐
Heart attack	☐	High cholesterol	☐		

Respiratory

Asthma	☐	Emphysema	☐	Bronchitis	☐
Pulmonary embolism	☐				

Gastrointestinal

Peptic ulcer disease	☐	Hepatitis	☐	Liver failure	☐
Gall stones	☐				

Kidney

Kidney stones	☐	Renal failure	☐	Bladder infections	☐

Neurological

Stroke	☐	Seizures	☐	Dizzy spells	☐
Blackouts	☐				

Others

Diabetes	☐	Thyroid problems	☐
Cancers	☐	Details _____	

Allergies _____

Surgical History

Have you had any previous operations and if so, when?

Medications

What medications do you take and how often?

Do you take any herbal preparations? _____

Do you smoke? Yes ☐ No ☐ How much? _____

Do you drink alcohol? Yes ☐ No ☐ How much? _____

DR JACQUELINE McMASTER'S – CONSULTATION FEES

We wish to advise that Dr Jacqueline McMaster's standard fees for consultation are above the government determined schedule fees.

I, _____, hereby acknowledge that I am seeing Dr McMaster as a private patient (not Worker's compensation, Third Party or any other types of compensable injury). I understand that she will **not** be preparing medico-legal reports for me or providing reports or correspondence to any insurance company or solicitor. **I understand that if any unpaid account is not settled within 30 days, a late payment fee of 25% will be incurred and the matter referred to our collection agency.**

The Privacy Act 1988 and its recent amendments formalized the already existing and acknowledged privacy obligations of our practice. Dr McMaster and staff collect information from patients primarily to provide proper patient care and treatment. We have a legal and ethical duty to protect patient information. Patient information may have to be disclosed to other health professionals so that healthcare is not compromised.

SIGNED: _____ **DATE:** _____

WITNESS: _____

WORKER'S COMPENSATION,THIRD PARTY OR OTHER COMPENSABLE INJURY

I, _____, hereby acknowledge that I am seeing Dr McMaster for her assessment, advice and if necessary, surgical management of my condition which is covered under Worker's compensation, Third party or compensable injury. I understand that I am responsible for payment of all consultation fees incurred at the time of consultation.

I hereby authorise that the information concerning my condition and treatment may be forwarded to my Worker's compensation Insurer, Third party or other compensable Insurer. I understand that Dr McMaster **does not** provide medico-legal reports for solicitors.

I undertake to be **fully responsible** for all outstanding fees for consultations and treatment. **I understand that if any unpaid account is not settled within 30 days, a late payment fee of 25% will be incurred and the matter referred to our collection agency.**

SIGNED: _____ **DATE:** _____

WITNESS: _____