The Retina & Macula Centre

DR DAVID J HILFORD
M.B.B.S (Hons), F.R.A.N.Z.C.O., B.Ed.,Dip.T.
Surgery & Diseases of the Retina, Vitreous & Macula

All Mail: PO Box 787, Spring Hill QLD 4001
Phone: 1300 4 RETINA (738 462)
Fax: (07) 3831 6707

PATIENT INFORMATION FORM

(PLEASE PRINT VERY CLEARLY)

Dr/Mr/Mrs/Ms/Miss (please circle) **Surname**: _____

Given Names: _____

Date of Birth: _____ / _____ / _____

Address: _____

_____

State: _____ **Post Code**: _____

Contact Details: **Home**: _____

Work: _____

Mobile: _____

Email: _____

Next of Kin:_____ **Contact Number:**

Medicare Card Number: _____ **Reference No**: ____
(The number next to your name)

Medicare Card Expiry Date: ____ / _____

Pension/Concession Card Number (if applicable): _____

Pension/Concession Card Expiry: ____ / ____ / _____

Private Health Fund (if applicable): _____

Private Health Fund Membership Number (if applicable): _____

Veterans Affairs Number (if applicable): _____

White/Gold Card (please circle)

Specific Problem - White Card Holders Only: _____

Your Usual General Practitioner's Name: _____

Your General Practioner's Address: _____

_____

Your Optometrists Name: _____

Optometrist Address: _____

_____

Any Medication Allergies: _____

Current Medications: _____

_____

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PRIVACY FORM
PATIENT HEALTHCARE INFORMATION CONSENT FORM

We require your consent to collect personal information about yourself. Please read through this information carefully and sign where indicated below.

This medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with some of your personal details and medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs.
This means we will use the information you provide us 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, these include treating doctors, optometrists and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals.
- Disclosure to other doctors in the practice, locums, and by registrars attached to the practice for the purpose of patient care and teaching. Please let us know if you do not wish to have your records assessed for these purposes and we will note this on your record.
- Disclosure for research and quality assurance activities to improve individual and community health care and practice management. You will be informed if and when such activities are being conducted and given the opportunity to not be included in such activities.

In addition to signing this form you give your consent to having your eyes dilated for retinal examination. Whilst dilating the eye normally does not cause any concerns, there is a minor risk (less than 1 in 1,000) of angle closure glaucoma which although treatable, may potentially cause decreased vision. If you experience a sudden, severely red, painful eye with possible nausea/vomiting after dilation please advise Dr Hilford immediately and otherwise contact your closest hospital emergency department.

I have read the information above and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling patient information.

I understand that I am not obliged to provide any information requested but that my failure to do so might compromise the quality of the health care and treatment given to me.

I am aware of my right to access the information collected about me except in some circumstances where access may be legitimately withheld. I understand I will be given an explanation in these circumstances.

I understand that if my information is to be used for any other purpose other than set out above my further consent will be obtained.

I consent to the handling of my information by this practice for the purpose set out above, subject to any limitations on access or disclosure that I notify that practice of.

Signed: _____ Date: _____
Patient to sign