Complete ENT Pty Ltd
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completeENT

PATIENT DETAILS

PERSONAL DETAILS:

Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Mstr ☐ Dr ☐ Other: _____

First Name: _____ Address: _____

Surname: _____ _____

Middle Name: _____ Suburb: _____

Preferred Name: _____ State: _____ Postcode: _____

DOB: _____ Gender: ☐ Male ☐ Female ☐ Unspecified

Home Ph: _____ Work Ph: _____ Mobile: _____

Email: _____

Aboriginal or Torres Strait Islander? ☐ Yes ☐ No Cultural background: _____

Is English your first language? ☐ Yes ☐ No If no, is an interpreter required? ☐ Yes ☐ No

Medicare No: _____ Ref: _____ Expiry: _____

Next of Kin details:

Name: _____ Relationship: _____ Phone: _____

For patients under 18 years, please complete the following Claimant details:

Claimant Medicare Ref No: _____ Claimant DOB: _____

Private Hospital Insurer: _____ Membership No: _____

DVA No: _____ Colour: ☐ Gold ☐ White ☐ Blue *Condition:* _____

Pension/Health Care Card No: _____ Expiry: _____

Workcover Claim No: _____ Employer: _____

REFERRAL DETAILS:

Referring Doctor: _____ Referral Date: _____

Usual GP:
(if not referrer) _____

Usual GP Practice: _____

Other Treating Practitioners: _____

PRIVACY CONSENT:

At **CompleteENT** we value the doctor-patient relationship and acknowledge that patient privacy is vital. The Privacy Act 1988 and its recent amendments formalised the already existing and acknowledged privacy obligations of our practice.
You are required to consent to the collection of your personal information, and for its use in the following ways:

- Administrative and billing purposes, including compliance with Medicare requirements.
- Disclosure of information to other healthcare workers involved in your healthcare for the purpose of patient care and teaching.
- Use of de-identified healthcare data for the purposes of research and quality assurance activities to improve individual and community health care and practice management.
- To comply with any legislative or regulatory requirements, such as notifiable disease reporting.
- At the request of our medical defence organisation, Avant Mutual Group. If you wish to know whether your health information is held by this organisation you may write to: PO Box 746, QVB NSW 1230.
- For reminders and recalls which may be sent to you regarding your healthcare and management.

Patients who wish to look at their information held by this practice or who may have queries about privacy of information are welcome to discuss these matters with their treating doctors. You can assist in maintaining the accuracy of your information by advising the practice of any changes to your personal contact details. You can request a copy of the **CompleteENT** Privacy Policy, or visit our website www.completeent.com.au for further details about the collection, use and disclosure or your health information.

I consent to the handling of my information by CompleteENT for the purposes set out above:

Signature: _____ Print Name: _____

(Guardian to complete if patient under 18 years)

Date: _____

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PATIENT DETAILS (Cont.)

How did you find out about CompleteENT?

☐ Website ☐ Google ☐ GP Referral ☐ Specialist Referral ☐ Friend or relative ☐ Other

Payment is required on the day of consultation.
Eftpos facilities are available and we can process your claim through to Medicare for you to receive a rebate to your bank account.
For information regarding billing arrangements for associated services from allied health practitioners such as pathology and radiology, these details should be sought directly from the health provider for the service.

Please discuss any queries concerning financial arrangements with your doctor.

This practice may send appointment reminders, recall reminders and messages via SMS (mobile text message).

*Please tick here if you **do not** wish to receive SMS* ☐

MEDICATIONS - Please list all current medications including aspirin, over the counter, herbal or vitamin preparations:

MEDICAL CONDITIONS - Do you have a history of any of the following? *(Please tick all that apply)*

☐ Asthma ☐ Blood clots ☐ Excessive bruising ☐ Heart problems
☐ Bleeding disorders ☐ Diabetes ☐ Headaches ☐ Other *(please list below)*

ALLERGIES - Have you ever had previous reaction to any of the following? *(Please tick all that apply)*

☐ Anaesthetics ☐ Aspirin ☐ Antiseptic lotion/cream ☐ Other medication
☐ Sulphur ☐ Adhesive tapes ☐ Local anaesthetic agent *Details:*

Do you have any known allergies? ☐ Yes *(Please list below)* ☐ No

PAST SURGERY - Please list all previous surgical procedures:

Year: Type of surgery:

SOCIAL HISTORY

Are you a smoker? ☐ No ☐ Yes Cigarettes/cigars per day: _____

Do you drink alcohol? ☐ No ☐ Yes Drinks per week: _____