PATIENT INFORMATION FORM *Thank you for taking the time to answer all the questions*

☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master ☐ Other (specify)

Family Name					
Given Names					
Date of Birth		Preferred Name			
Home Address					
				Post Code	
Postal Address				Post Code	
Home Phone		Work Phone			
Mobile Phone					
Local Doctor					
Other Associated Doctors					

MEDICARE NUMBER											Valid To	
MEDICARE REFERENCE NUMBER		***This is the number next to your name on the Medicare card***										
Department of Veteran Affairs							☐ Gold ☐ White				Expiry Date	

PRIVATE HEALTH INSURANCE	• Yes • No
If Yes - Does this health insurance cover you in a Private Hospital? ☐ Yes ☐ No	
Name of Health Fund	
Membership Number	

NAME OF FIRST CONTACT PERSON	
Contact Phone Number	
Relationship to You	
May we tell your contact person ☐ Everything ☐ Nothing	

Personal Information is collected in compliance with privacy laws. The information may be shared with other doctors in the interest of patient care. In the event of late, or non-payment, this practice reserves the right to charge interest and may result in liability for commissions or legal costs. Personal contact details (but not medical information) may also be used by legal or collection agents.

Dr Christopher Steinfort
156 Bellerine Street
GEELONG VIC 3220

THIS PRACTICE <u>DOES NOT BULK BILL</u> & REQUIRES <u>FULL SETTLEMENT</u> OF ACCOUNTS AT THE TIME OF CONSULTATION

Patient/Guardian Signature: …… Date: ……

Dr. Christopher Steinfort M.B.B.S, F.R.A.C.P, F.C.C.P.
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Dr Chris Steinfort's Medical Practice

PRIVACY POLICY

Personal Information

Our practice ensures your patient file is regarded as a private and personal document. It is maintained in a safe and secure environment which it complies with all current State and Federal Privacy Legislation.

Collection of information

Our practice gains personal information from your patient questionnaire which you will receive on your first consultation with Dr Christopher Steinfort. The questionnaire covers personal information which will be held by the practice such as: name, date of birth, contact details, next of kin, local doctor and referring doctors, private health insurance, Medicare card and general medical history.

Purpose of disclosing information

On occasions Dr Steinfort is requested to provide health information to third parties such as insurance companies, WorkCover or the Transport Accident Commission (TAC) who can request a medical report. Before such information is released we would require your written consent before doing so. Your personal information will not be released to these organisations unless this permission is granted by you.

Storing of personal information

Some of your personal details will be computerised for purposes of billing and appointments. This data is only accessible to Dr Steinfort and his secretarial staff. You can be reassured that your information will be stored safely as this practice is secured after hours by security surveillance.

You of course can request access to your personal information and medical records at any time by written request. Our practice is able forward your medical history and personal information to another medical practitioner as long as we have a request in writing from you stating your name, address and contact number along with information of the medical practice.

I have read and understand the above policies.

I,……. give my consent to Dr Christopher Steinfort and his practice to collect and record information regarding my health, and to share information with other health service providers where necessary only after requesting and receiving your written consent to release such information to ensure the provision of quality medical care. I understand that my privacy will be respected.

Signed……Date…….