GLEZOS

Patient Information Sheet

Title | **First Name** | **Preferred Name** (if different from first name) | **Middle Name**

Surname | **Date of Birth**

Home Phone..... Work Phone..... Mobile .....

Email ..... Occupation .....

Address .....

Suburb..... State ..... Postcode .....

Next of Kin: *Name* ..... *Relationship* .....

Contact number .....

Medicare

Medicare Number (10 digits) | Ref No (left of your name) | Valid to MM YYYY

Private Health Fund

Fund Name | Membership Number | Ref No

For patients under 18 years old – Parent's Details (required for your Medicare rebate)

Parent's full name:
DOB:
Medicare card number & position on card:

Do you have any of the following cards: ☐ Health care card ☐ Age Pension ☐ DVA

Card Number ..... Valid to .....

Referrer ☐ GP ☐ Physiotherapist ☐ Other

Usual GP..... Phone number.....

GP Address .....

Physiotherapist ..... Phone number.....

Physio Address .....

THIS FORM IS <u>DOUBLE-SIDED</u>, PLEASE TURN OVER. MORE QUESTIONS ON THE OTHER SIDE →

GLEZOS

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Please circle YES or NO to the following questions

Are you on blood thinners or anti-platelets (please list):	YES/ NO	High blood pressure	YES/ NO
Are you on medications for diabetes (please list):	YES/ NO	Heart attack, stent or bypass surgery	YES/ NO
Pacemaker/ defibrillator	YES/ NO	Pregnant	YES/ NO
Kidney or liver problems	YES/ NO	Previous adverse reaction to anaesthetic	YES/ NO
Joint replacements (please list):	YES/ NO	Previous deep vein thrombosis (DVT) or pulmonary embolism (PE)	YES/ NO
Cancer (please list):	YES/ NO	Have been told you have resistant organism eg MRSA	YES/ NO
Allergies (please list):	YES/ NO	Other:	

Third Party Claim Details Workers compensation ◯ CTP ◯

Injury …… Date of Injury

Claim number ……Insurer……

Case Manager……Phone……..Email……

Employer……Phone……..Email……

Employer Address/Contact……

Consent to Collect Patient Information

- This practice collects information from you for the primary purpose of providing you quality health care. We require you to provide us with your personal details and medical history so that we may properly assess, diagnose, treat, and proactively manage your health care needs. Our practice may utilise an AI-powered note taking tool called Heidi to accurately and efficiently transcribe the details of your consultation. Your consultation will not be recorded at any time. Heidi ensures that we can focus more on you and less on manual note taking, enhancing the quality of care you receive.
- The information you provide may be used in the following ways:
  1. Administrative purposes in managing our practice.
  2. Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
  3. As advised by you, disclosure to other healthcare providers involved in your care, including treating doctors and providers outside this practice.
- By signing this consent form, you agree to the following:
  - You understand the reasons why your information must be collected and consent to its use as outlined above.
  - While you are not obligated to provide any requested information, you acknowledge that failure to do so might directly or indirectly compromise the quality of health care and treatment provided.
  - You are aware of your right to access the information collected about you, except in circumstances where access may legitimately be withheld, with an explanation provided in such cases.
  - You consent to the handling of your information by this practice, including its use by the AI tool Heidi, which will remain compliant with Australian privacy laws.

Signature: _____ Name: _____ Date: _____