DR DAVID BADE

PAEDIATRIC & ADULT
ORTHOPAEDIC SURGEON

Dutton Park Suites
163 Annerley Rd
Dutton Park Q 4102

Telephone (07) 3059 6259
Facsimile (07) 3036 5932

NEW PATIENT REGISTRATION

Patient Name:______________________________ Date of Birth: __/______/______ Age:____

Address:______________________________ Suburb:____________________ Post Code:_____

Telephone: Home: _____________ Work: _______________ Mobile: ______________ Email: ________________________

Medicare No: ________________________ Ref:____ Expiry: ______________ WorkCover Claim:____________________

Private Health Fund:__________________________ Membership Number: ________________ DVA:_________________

GENDER: Male ☐ Female ☐ MARITAL STATUS: Single ☐ Married ☐ Defacto ☐ Separated ☐ Divorced ☐ Widowed ☐

Next of Kin:____ Telephone: __________________

Regular GP:_________________________ Practice Name:_____________________________ Telephone:____________

Do you have any allergies, if YES, please list: ____

Are you currently on any regular prescription medications (ie Warfarin, Xarelto etc)?

____

Do you regularly take any over the counter Vitamins (ie Fish Oil capsules etc) ? ____________________________________

Do you suffer from Diabetes? Yes / No (please circle)
If yes, what dose of injectable insulin are you using? ____

If the patient is under 18 years of age please provide the following information:

Parent/Guardian Name: _____________________________ Parent/Guardian Medicare No:_________________________

Parent/ Guardian Ref: ____ Medicare Expiry:______________ Parent/Guardian Date of Birth:___/______/______

PRIVACY INFORMATION & CONSENT

As a patient of our medical practice, we require you to provide us with your personal details and a full medical history, so that we may properly assess, diagnose, treat and be proactive in your health care needs. We aim to protect the privacy of your health and personal information. You can request a copy of our practice privacy policy, which includes information about the collection, use and disclosure of your health information. We require your consent to collect your personal information, and for its use in the following ways:

- Administrative purposes;
- Billing purposes (including compliance with Medicare and Health Insurance Commission requirements);
- Disclosure to others involved in your healthcare. This includes your treating Doctor and other 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 referrals;
- For research and quality assurance activities to improve individual and community health care and practice management. Only information that does not identify you is used in these circumstances;
- To comply with any legislative or regulatory requirements, such as notifiable diseases;
- For reminders and recalls which may be sent to you regarding your health care and management.

By signing this privacy information and consent document, I consent to having my information transmitted electronically to authorised third parties. Additionally, I consent to the handling of my information by this practice for the purpose set out above.

Name:_____________________________ **Signature:** _________________________ **Date:** ________/______/______