Dr. Jeff Ling

Patient Information Form

(Please circle one) **Dr Mr Mrs Ms Miss Master** **Other: _____**

Surname:_____ Given Names:_____

Address:_____Post Code:_____

Date of Birth: _____Age:_____ Home Phone:_____

Email: _____ Mobile Phone:_____

Occupation: _____ Medicare No: _____ No: ____

Health Fund: _____ Health Fund No:_____

For Medicare claiming purposes if under 16 years old, please provide Parent Details

Medicare No: _____ No. Next to Name: _____

Parent Name: _____Parent DOB: _____

Health Fund: _____ Health Fund Membership No: _____

DVA (Veteran's Affairs gold card only):_____

Referring Doctors Name & Address:_____

_____**Post Code: _____**

GP's Name & Address:_____

_____**Post Code: _____**

Physiotherapist Name & Address:_____

_____**Post Code: _____**

Allergies:_____

Medications:_____

WORKERS COMPENSATION & THIRD PARTY PATIENTS ONLY

Insurance Company Name & Address:_____

Claim Number: _____Case Manager: _____

Case Manager's Ph: _____Case Manager's Fax: _____

Employer (if applicable): _____ Occupation: _____

Date of Injury: _____

Solicitors Name & Address (if applicable):_____
_____

PRIVACY STATEMENT

As a patient of Dr Jeff Ling, a medical record containing personal information will be maintained throughout your treatment. These records will contain information including, but not exclusive to, your name, address, date of birth, Medicare number and your referring doctor's details. During the period of assessment and ongoing management, information of relevance is recorded in clinical notes. These records are stored securely and may be kept for up to seven years following your last consultation. If necessary, for the continuity of your medical care, this information may be shared with other health practitioner's involved in your treatment. In certain circumstances there may be a legal obligation to disclose clinical information. A full copy of our privacy policy is available on request.

Permission is given to Dr Jeff Ling to collect and release information on my medical history in order to provide appropriate health care, medical research and audit purposes. To perform an appropriate orthopaedic examination pertaining to your clinical history relating to your orthopaedic problem.

I take responsibility for the payment of my accounts.

Signature: **Date:**