MiPAIN - *PATIENT INFORMATION FORM*

Please return to either:

P.O Box 3576, HERMIT PARK QLD 4812 OR Email: reception@mipain.com.au OR Fax: (07) 4795 4345

PATIENT DETAILS: (PLEASE PRINT)

Title:_____ Given Name/s: _____ Surname: _____

Preferred Name: _____ Date of Birth: __ __ / __ __ / __ __

Address: _____ Postcode: _____

Phone (home): _____ (work): _____ (mobile): _____

Email: _____ Occupation: _____

Parents' Name (if under 18 years old): _____

NEXT OF KIN DETAILS:

Title: _____ Given Name/s: _____ Surname: _____

Relationship to patient: _____

Phone (home): _____ (work): _____ (mobile): _____

MEDICARE : **The name on your Medicare card must be the same name registered with your Health Fund**

Medicare No: __ __ __ __ __ __ __ __ __ __ Patient No: __ Valid to: __ __ / __ __ / __ __

VETERANS' AFFAIRS:

DVA Card number: _____ Gold / White Valid to: __ __ / __ __ / __ __

White card – Accepted condition/s: _____

_____

HEALTH INSURANCE DETAILS: Private Health Fund: _____

Membership No: _____ Patient number on card: _____

Tier: eg. Gold, Silver, etc. _____

IMPORTANT NOTE: You must check with your private health fund that you have served relevant wait periods and have in hospital cover included in your policy.

GENERAL PRACTITIONER:

Name: _____

Medical Practice: _____

(P.T.O to complete page 2)

REFERRING DOCTOR:

Name: _____

ALLIED HEALTH: Please complete if you would like correspondence to be shared with treating Allied Health.

Physiotherapist: _____ Centre: _____

AUSTRALIAN DEFENCE FORCE PERSONNEL:

PMKeyS/EP ID no: _____ DAN no: _____

WORKCOVER/INSURANCE CLAIM/ ANY OTHER THIRD PARTY INVOLVEMENT:

Claim No: _____

Case Manager/Contact person's name : _____ Phone: _____

For Workcover Claims: Employer's Business Name: _____

Address: _____ Postcode: _____

Contact person: _____ Phone: _____

DECLARATION/DETAILS OF PERSON RESPONSIBLE FOR ACCOUNT:

▢ Self ▢ Other **(ONLY COMPLETE DETAILS IF 'OTHER' HAS BEEN SELECTED)**

Title: _____ Given Name/s: _____ Surname: _____

Address: _____ Postcode: _____

Phone (home): _____ (work): _____ (mobile): _____

This medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide your personal details and medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. We will use the information you provide in the following ways:

1. Administrative purposes in running our medical practice.
2. Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
3. Disclosure to others involved in your health care, including treating doctors, Specialists and other Medical Practitioners for the provision of quality health care.

By proceeding with this consultation:

- ▢ I certify that the above information is true to the best of my knowledge.
- ▢ I consent to the handling of my information by this practice for the purposes set out above.
- ▢ I acknowledge full responsibility for accounts rendered by MiPain/Dr Jason Scott, including any shortfall in reimbursement by the health fund or other third parties involved.
- ▢ I also acknowledge that any correspondence between Dr Scott and my referring doctor/GP is not to be released to any third party without the express consent of Dr Scott. Such correspondence is not suitable for the purposes of litigation and will therefore not be released without an accompanying subpoena from the Courts.

Patient's name (please print): _____

Signature: _____ Date: _____