DR. BRENT SKIPPEN
EYE & OCULOPLASTIC SURGEON
RIVERINA CONSULTING ROOMS

# New patient

## Privacy Policy Statement and Consent Form - We Respect Your Privacy

This practice provides high quality continuing care for you. In compliance with the Privacy Legislation* and consistent with maintaining confidentiality and trust with your doctor, the practice wishes to inform you;

- Information collected about you requires your consent
- Why, how and who we will disclose this information to, can for the following purposes:
- Diagnosis and treatment of your problem, including communicating with practice staff, specialities and other healthcare providers involved in your care;
    - Healthcare prevention
    - Accreditation and Quality Assurance
    - Billing and collection of professional fees
    - For work-related or medico-legal reasons
    - Teaching and research
- We will require your consent to use this information for any of these purposes
- By writing to your doctor you can request access to information we hold about you. An administration fee will apply.
- An explanation will be provided to you if legislation prevents certain information from being disclosed to you.
- You can discuss any concerns about how we handle your information.

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## Consent

I hereby consent Dr Skippen or the Eye Registrar consulting with me and taking appropriate notes to enable him/her to make an informed decision regarding my health. This may involve script writing, referrals to other specialists and corresponding with some regarding management of my health.

Signature of Patient/Person Responsible: .....

Date:...../...../.....

*as prescribed by the Office of the Federal Privacy Commissioner Guidelines on Privacy in the Private Health Sector.

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Medicare Card No: ☐☐☐☐ ☐☐☐☐☐ ☐ Expires: ...../...../.....

No. next to name: ☐

Centrelink Concession Card No: ☐☐☐ ☐☐☐ ☐☐☐ ☐

Expires: ...../...../..... Colour: .....

Department of Veterans' Affairs: ☐☐☐☐☐☐☐☐☐

Expires: ...../...../..... Colour: .....

Private Health Cover if Hospital Admission is required: ☐ Yes ☐ No - Fund Name:.....

Private Health Fund Membership No: ☐☐☐☐☐☐☐☐☐ No. next to name: ☐

Is this a Worker's Compensation Case? ☐ Yes ☐ No

Employer's details: .....

36 DOCKER STREET WAGGA WAGGA 2650
PH. 02 6925 2700 INFO@BRENTSKIPPEN.COM.AU
WWW.BRENTSKIPPEN.COM.AU

## Patient's Details

Name:.....(as it appears on the Medicare card)

DOB:...../...../..... Title: (circle) Sr / Dr / Mr / Mrs / Ms / Miss / Mast / Other.....

Country of Birth: ..... Aboriginal or Torres Straight Islander? ☐ Yes ☐ No

Home Ph: ..... Work Ph: ..... Mobile: .....

Address: .....

Next of kin/Person to contact in an emergency: Name: ..... Ph: .....

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## Patient Health Questionnaire:

Your General Practitioner: ..... Your Optometrist: .....

**Have you any history of eye injuries?** ☐ Yes ☐ No

**Have you any history of eye operations?** ☐ Yes ☐ No

**Have you any history of eye laser treatment?** ☐ Yes ☐ No

Details if known: .....

**Are you using eye drops at present?** ☐ Yes ☐ No

If yes, names if known: .....

**Have you used eye drops for long periods in the past?** ☐ Yes ☐ No

(ie: more than two weeks) details if known: .....

**Do you take any other medications?** ☐ Yes ☐ No

(if yes, please list all tablets, capsules, puffers, nebulisers, liquids, injection, eye drops etc)

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**Do you take any form of Aspirin?** ☐ Yes ☐ No

**Do you take Warfarin?** ☐ Yes ☐ No

**Do you take Clopidogel**

(Plavix / Iscover / Coplavix / Duocover / Piax)? ☐ Yes ☐ No

**Are you allergic to any medications or do you have any other allergies at all?**

If so, what: .....

Do you suffer from or are you being treated for: (please circle)

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Arthritis | Yes | No | Heart Disease | Yes | No | Other lung problems | Yes | No |
| Asthma | Yes | No | High Blood Pressure | Yes | No | Stomach or | | |
| Diabetes | Yes | No | Stroke | Yes | No | Duodenal Ulcers | Yes | No |

Any other heath problems? .....

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