DR BRENT SKIPPEN
OPHTHALMOLOGIST AND EYELID 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.

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.

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: .....

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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