

# Dr Peta Higgs

## PATIENT INFORMATION SHEET

Title Mrs Ms Miss Dr

Full Name \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_

Postcode \_\_\_\_\_

Phone \_\_\_\_\_ Mobile \_\_\_\_\_ Work \_\_\_\_\_

Email \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Phone \_\_\_\_\_

Normal GP if different to referring Doctor \_\_\_\_\_

Medicare Card Number \_\_\_\_\_ Ref No. next to name \_\_\_\_\_

Expiry date \_\_\_\_/\_\_\_\_

DVA Card No. \_\_\_\_\_ White /Gold (Please circle)

Do you have private health cover? Yes / No

Name of Insurer \_\_\_\_\_ Member No. \_\_\_\_\_

Work Cover Claim Number (if applicable)

How many children have you had? \_\_\_\_\_

Please list your current and regular medications

Please list any allergies to medications

Please list any significant medical history

Please list past surgery/operations and previous illnesses/ injuries

Last Cervical Screening Test (Pap Smear) \_\_\_\_\_

### SMOKING HISTORY

- Never
- Former smoker
- Current smoker
- Number of years smoking  
\_\_\_\_\_ yrs

### ALCOHOL

- Non-drinker
- Rarely
- Few times/week
- Daily

**CONSENT**

I consent to the disclosure of my personal health information by Dr Peta Higgs onto other health providers directly or indirectly involved in my personal health care or medical treatment. I also consent to any imaging that may be required to be performed by Dr Peta Higgs and that de-identified data may be collated on our database for quality control purposes. Patients who wish to look at their information held by this practice or who have other queries about privacy of information are welcome to discuss these matters with their treating doctors.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Patient Survey:**

Did you find staff helpful and courteous at the time of booking your appointment?

(please circle)      Yes / No

Are there any areas you feel could be improved upon in relation to your experience with our practice?

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.....  
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Thank you for taking the time to complete this survey. Your assessment of our practice allows us to facilitate improvements.

***PLEASE NOTE:***

Our office is located at The Buderim Private Hospital. Please park in the multi-story car park and take the green lift to the second floor, then right to Women’s Health on Buderim. We require you to bring any relevant scans, your doctor’s referral letter, your Medicare card and also Private Health Fund card. Doctor’s fees would have been advised when scheduling your appointment however if you should have any queries, please don’t hesitate to contact our office. A late payment fee of 15% will be applied to accounts outstanding over three months unless prior arrangements have been made with our office. Thank you.

***Privacy Statement***

*We value the doctor-patient relationship. Patient privacy is vital to such a relationship. The Privacy Act 1988 and its recent amendments formalise the already existing and acknowledged privacy obligations of our practice.*

*Our doctors and staff collect information from patients primarily to provide appropriate care and treatment. We have a legal and ethical duty to protect patient information. Patient information may have to be disclosed to other doctors, nurses, therapist and medical technicians so that proper health care is not compromised.*

*The doctors in this practice are members of various medical and professional bodies including medical defence organisations. These organisations provide valuable services to their members. They require their members to provide information in relation to their practice which may include patient information.. Our medical defence organisation is Avant Insurance Limited. If you wish to know whether your health information is held by this organisation, you may write to them at: The Privacy Officer, Avant Medical Insurance Limited, Level 6, Darling Park 3, 201 Sussex Street, Sydney NSW 2000 or contact them on 02 9260 9000.*