Patient Details

PERSONAL DETAILS

Family Name		**Title**
Given Name(s) *(as appears on Medicare Card)*		
Preferred Name		
Date of Birth	**Gender** ❑ Male ❑ Female ❑ Other	
Occupation		

CULTURAL

Knowing your cultural background can help us provide health care that meets your individual needs.

Are you of Aboriginal or Torres Strait Islander origin?

❑ No ❑ Yes, Aboriginal ❑ Yes, Torres Strait Islander ❑ Yes, Aboriginal & Torres Strait Islander

Other cultural background (eg Mediterranean, Asian, African etc)	Country of Birth

CONTACT DETAILS

Residential Address		
Postal Address		
Home Phone	**Mobile**	**Work Phone**
Email Address		

Our practice uses a reminder system to help maintain your health. The practice sends reminders by post, email, telephone or SMS for appointments and procedures like vaccinations, cervical screening and other health reviews.

I consent to being contacted with reminders to help me maintain my health. Yes ❑ No ❑

HEALTH COVER

Medicare Card Number		**Ref No.**	**Expiry**
Pension / Health Care Card Number			**Expiry**
Pension Card Type			
DVA Number		**Gold / White** *(please circle)*	**Expiry**
Private Health Cover			

NEXT OF KIN

Name		**Relationship** ❑ Spouse ❑ Parent ❑ Guardian ❑ Other	
Address			
Home Phone	**Work Phone**	**Mobile**	
Emergency Contact Name		**Contact Number**	

MINORS

Parent / Guardian Name		**Date of Birth**	
Medicare Card Number		**Ref No**	**Expiry**
Comments			

Your Signature	**Date**
Print Name	

PLEASE HAND THIS FORM TO THE RECEPTIONIST

Health Information
Collection and Use Consent Form

As a patient of our medical practice we require you to provide us with your personal details and a full medical history, so that we may properly assess, diagnose, treat and be proactive in your health care needs.

We aim to protect the privacy and secure storage of your health information. You can request a copy of our privacy policy, which includes information about the collection, use and disclosure of your health information.

We require your consent to collect personal information about you and to use the information you provide in the following ways. Please read this consent form carefully, and sign where indicated below.

- Administrative purposes in running our medical practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your healthcare including treating doctors and specialists outside this medical practice. This may occur though referral to other doctors, or for medical tests and in the reports or results returned to us following referrals.
- Disclosure to other doctors in the practice, locums etc. attached to the practice for the purpose of patient care and teaching.
- For research and quality assurance activities to improve individual and community health care and practice management. Usually information that does not identify you is used but should information that will identify you be required you will be informed and given the opportunity to "opt out" of any involvement.
- To comply with any legislative or regulatory requirements eg notifiable diseases.
- For reminder letters which may be sent to you regarding your health care and management.

You can decline to have your health information used in all or some of the ways outlined above but it may influence our ability to manage your health care to provide the best outcome for you.

I have read the information above and understand the reasons why my information must be collected	❑
I understand that I am not obliged to provide any information requested of me, but failure to do so may compromise the quality of health care and treatment given to me	❑
I am aware of my rights to access the information collected about me, except in some circumstances where access may be legitimately withheld. I will be given an explanation in these circumstances.	❑
I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.	❑
I consent to the handling of my information by the practice for the purpose set out above, subject to any limitations on access or disclosure of which I notify this practice.	❑
OR	
I am unsure and would like to discuss this further with someone from the medical practice before I sign.	❑

Name	Date of Birth
Signature	Date
Signed as Guardian for child	Name *(print)*

PLEASE HAND THIS FORM TO THE RECEPTIONIST