|  |  |
| --- | --- |
| Title: Miss / Ms / Mrs / Master / Mr / Other: |  |
| Surname: | First Name: |
| Date of Birth: | Gender: M / F |
| Address: | Suburb: Post Code: |
| Ph (H): Mobile: |  Work Number: |
| Email:  | Occupation: |

**Personal Details:**

|  |
| --- |
| Medicare Number: **\_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_** Number Next to Name: **\_\_**  Expiry Date: **\_\_\_\_ /\_\_\_\_** |
| Concession Card (Please Circle) **Healthcare Concession Card Pensioner Concession Card**Card Number: **\_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_** Expiry Date: **\_\_\_/\_\_\_/\_\_\_\_** |
| DVA Number: (if applicable) **\_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_** Expiry Date: **\_\_\_/\_\_\_/\_\_\_\_** |

**Cultural Background:**

Knowing your cultural background can help us provide healthcare that meets your individual needs. There may be Commonwealth programmes that can assist us in your healthcare.

|  |
| --- |
| Are you of Aboriginal or Torres Strait Islander descent? (please tick)☐ No ☐ Yes Aboriginal ☐ Yes Torres Strait Islander ☐ Both Aboriginal & Torres Strait Islander |
| Cultural Background (Mediterranean, Asian, African etc): |
| Country of Birth: |

**Next of Kin: (A Next of Kin is your closest living blood or marital relative or relatives, like your children, spouse, siblings, or parents. It's common to contact a next of kin when you have been injured or are terribly sick.)**

|  |
| --- |
| Name: Relationship: Mum, Dad, Wife, Husband (Please Circle)  Other: |
| Address: |  Suburb: Post Code: |
| Ph (H): Mobile: |  Work Number: |
| **If the patient is a child and you are the attending guardian, please provide your Date of Birth and Medicare details so the account can be addressed to you.** |
| Date of Birth: |
| Medicare Number: **\_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_** Number Next to Name: **\_\_**  Expiry Date: **\_\_\_\_ /\_\_\_\_** |

**PLEASE TURN OVER 🡪**

**Emergency Contact: Same as Next of Kin: (please tick)** ☐

|  |
| --- |
| Name: Relationship: Mum, Dad, Wife, Husband (Please Circle)  Other: |
| Address: |  Suburb: Post Code: |
| Ph (H): Mobile: |  Work Number: |

**Please notify us promptly of any changes in your contact details. Accurate contact details help us identify you and your medical records and allows us to contact you promptly about tests and results.**

**Significant Family History:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Collection Statement and Privacy Consent**

For the primary purpose of providing you with the best quality care, we need to collect personal information about you (including your health information). Your information will enable us to thoroughly assess, diagnose and provide appropriate treatment to you. If you do not provide this information to us, we may not be able to treat you. The personal information which we collect will also be used for:

* Administrative purpose;
* Clinical information will be captured to facilitate the best possible treatment;
* Billing purposes (either directly or through an insurer or compensation agency);
* Use within the practice with practice staff, other doctors for your ongoing treatment;
* Disclosure to other doctors and health professionals outside the practice involved in your healthcare;
* In the case of insurance or compensation claim it may be necessary to disclose and/or collect information that concerns your return to work to an insurer, your lawyer and/or your employer;
* For follow up reminders/recalls which may be sent to you regarding your health care and management; ″ disclosure legally required by law, such as notable disease;
* Where you are unable to act on your own behalf due to a health condition, we may need to discuss your health information with relatives or emergency contacts, in order that you are provided with appropriate care;

We do not disclose your personal information to overseas recipients. **Our practice uses a reminder and recall system to help you maintain your health. The practice sends reminders by post, email, telephone or text messaging/SMS for immunisations, procedures and other health reviews as well as recalling for abnormal results and follow up requested by consultants and hospital discharges.** Our full Privacy Policy is available on request in the waiting area. That policy provides guidelines on the collection, use, disclosure and security of your information. The Privacy Policy contains information on how you may request access to, and correction of your personal information.

**Consent:**

**Print Name of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Patient or Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**