

PATIENT DETAILS AND CONSENT FORM

Section A: Personal Details

Title	Surname	Given Names	
Gender Male/Female	Date of Birth / /	Marital Status Single/Married/De Facto/Separated/Divorced/Widowed	
Home Address			Post Code
Postal Address			Post Code
Telephone Number ()	Work Number ()	Mobile Number	
Email			
Medicare Card No	Medicare Reference No	Medicare Card Expiry Date /	
Pension/Health Care Card or Veterans Affairs No (if applicable)	Type of Veterans Affairs Card	Expiry Date	
Health Fund Name	Membership Number	Level/Excess if known	
Occupation			
Who can we contact in the event of an emergency?			
Name		Relationship to you	
Telephone Number ()	Work Number ()	Mobile Number	
Do you have an Advance Health Directive for end of life care? For more information please talk to your GP			Yes No

Section B: Cultural Background

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

Country of Birth			Other cultural background (eg, Mediterranean, Asian, African)					
Is English your first language?	Yes	No	If not, do you require an interpreter?	Yes	No	Please specify language		
Are you of Aboriginal or Torres Strait Islander origin?							Yes	No
Aboriginal		Torres Strait Islander		Aboriginal and Torres Strait Islander				

Section C: Consent

Our practice uses a reminder system to help you maintain your health. The practice sends reminders by post, telephone or SMS for procedures such as blood tests, vaccinations and others. Our practice also sends information to the Australian Childhood Immunisation Register and Pap Smear Register. These registers also send reminders.

I consent to being contacted with reminders to help me maintain my health:

Yes	No
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This practice collects information from you for the primary purpose of providing quality health care. In keeping with the *Privacy Act 1988* and *Australian Privacy Principles*, we wish to provide you with sufficient information on how your personal information may be used or disclosed.

By signing below, you (as a patient/parent/guardian) are consenting to the collection of your personal information, and that it may be used or disclosed by the practice for the following purposes:

- Administrative purposes in running our practice.
- Billing purposes, including compliance with Medicare requirements.
- Follow-up reminder/recall notices for treatment and preventative healthcare.
- Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals.
- Accreditation and quality assurance activities to improve individual and community health care and practice management.
- For legal related disclosure as required by a court of law.
- For the purposes of research only where de-identified information is used.
- To allow medical students and staff to participate in medical training/teaching using only de-identified information.
- To comply with any legislative or regulatory requirements e.g. notifiable diseases.
- For use when seeking treatment by other doctors in this practice.

Signature of patient or guardian	Date / /
If not patient signing – Your Name	Relationship to patient

We aim to protect the privacy and secure storage of your health information. You can request a copy of our Privacy Policy from one of our Reception Staff. This Policy includes information about the collection, use and disclosure of your health information.