

Patient Information Form & Privacy Statement

We are committed to providing our patients with the best care.
To do this it is essential that your health record is correct and kept up to date.



Please complete all fields of this form

PERSONAL DETAILS

Title	Dr <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Miss <input type="checkbox"/> Mast <input type="checkbox"/> Other <input type="checkbox"/>		
First Name		Middle Name	
Surname		Preferred Name	
Date of Birth	DD/MM/YY	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/>	
Ethnicity		Country of Birth:	
Do you identify as Aboriginal and/or Torres Strait Islander? Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> No <input type="checkbox"/>			
If Aboriginal or Torres Strait Islander, Are you Registered for Closing The Gap (CTG) Program? Yes <input type="checkbox"/> No <input type="checkbox"/> If not please ask your GP to provide you a form to register			
Languages Spoken Other Than English:			

OTHER DETAILS:

Medicare No.		Ref # on card		Expiry	MM/YY
D.V.A No.		Gold <input type="checkbox"/> White <input type="checkbox"/>		Expiry	
Pension/ Health Card No.		Pension <input type="checkbox"/> Health Care <input type="checkbox"/>		Expiry	DD/MM/YY
Residential Address					
Suburb		State		Postcode	
Postal Address		State		Postcode	
Phone Numbers	Home:	Mobile:		Work:	
Any Known Allergies	Please list known allergies				
Email Address					
Occupation					
Next of Kin					
Next of Kin Phone		Relationship with Next of Kin:			
Emergency Contact	<input type="checkbox"/> Same as Next of Kin				
Emergency Contact Phone No. / Address					

PARENT OR GUARDIAN DETAILS (Please complete this section if child is under 16 years of age)

First Name		Middle Name	
Surname		Mobile Number	
Date of Birth	DD/MM/YYYY	Relationship with Child	
Your Medicare		Ref # on card	Expiry MM/YY

LIFESTYLE HISTORY

Alcohol	Drinker <input type="checkbox"/> Non-Drinker <input type="checkbox"/>	How often do you drink per week:
Smoking	Smoker <input type="checkbox"/> Vaper <input type="checkbox"/> Non-Smoker <input type="checkbox"/> Ex-Smoker <input type="checkbox"/>	No. of Cigarettes you smoke per day: _____ Approximate quit date: DD/MM/YYYY
Exercise	Do you do any regular exercise: Yes <input type="checkbox"/> No <input type="checkbox"/> please specify type of exercise	

PLEASE TURN OVER TO COMPLETE OTHER SIDE

PRIVACY STATEMENT: Collection of Patients Information and Its Use
(Please read the following information, tick off and sign below)

As a patient of our medical practice, we require you to provide us with your personal details and other relevant information so that it can be registered in our system, assessed, and properly treated for your health needs.

Your Medical Record is a Confidential Document. It is the policy of our Practice to always maintain security of personal and health information and to ensure that this information is only available to authorized members of staff. This information is collected in **accordance** with the National Privacy Principles and is used to manage your health care. If you wish to view a copy of our Privacy Policy, please ask one of our team members.

We require your consent to collect personal information about you and to use the information you provide in the different ways: for example (a) For the use of administrative / operational purposes of our medical practice. (b) For Billing purposes, including compliance with Medicare and Health Insurance Commission requirements (c) Disclosure to others involved in your healthcare including treating doctors, other doctors, locum medical practitioners, registrars, trainees working within our group. Your information, also with other specialists and Allied health practitioners within or outside this medical practice. (d) To comply with any legislative or regulatory requirements e.g., notifiable diseases or for court summons. (e) For reminders (letters, SMS, and emails) which may be sent to you regarding your health and management. (f) to participate in research and quality improvement programs.

If you are not clear about any information or need further information – please talk to your doctors or Practice Manager.

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.	<input type="checkbox"/>
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.	<input type="checkbox"/>
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.	<input type="checkbox"/>
I consent to the handling of my information by the practice for the purpose set out above, subjected to any limitations on access or disclosure of which I notify in writing to the practice.	<input type="checkbox"/>
I consent to being contacted by SMS/ phone call / letter related to my Health Issues (you will receive SMS recalls related to your health)	<input type="checkbox"/>
I have read and understand the information provided above.	<input type="checkbox"/>

PLEASE TICK ABOVE ONCE READ

Please present to reception with Medicare Card and ID

Signature	Patient / Guardian Signature
Patient ID	No Patient ID required for under-age children, Guardian ID must be sighted by staff
Guardian ID	Guardian ID Must be Sighted for under-age children.
Date	DD/MM/YY

This section to be completed by staff

Checked By: Staff Name Signature..... Date ...DD/MM/YY...

(For Staff: Please make sure form is appropriately filled and all sections completed)