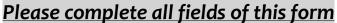
Patient Information Form & Privacy Statement

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.





PERSONAL DETA	AILS						Patient	File N	o#				
Title		Dr □ Mr	□ Mrs □	□ Ms □	Miss 🗆	Ma	ast 🗆 Ot	her					
First Name					М	iddle	Name						
Surname					Pr	eferr	ed Name						
Date of Birth					Gei	nder:	Male □	Fema	ale 🗆 Trans	sgender 🗆			
Ethnicity					Cou	untry	of Birth:						
Do you identify a	s Aborigir	nal and/or To	orres Strait	t Islander?	Aborig	inal [Torres	Stra	it Islander 🗆	No □			
If Aboriginal or Torr	es Strait Isl	ander, Are you	u Registered	d for Closing	The Gap	(CTG)	Program?	Yes 🗆	No □				
		If n	ot please ask y	our GP to provi	de you a fo	rm to re	gister						
Languages Spol	ken Othe	r Than Engl	ish:										
OTHER DETAILS	5:												
Medicare No.			(IRN) Ref # on				n card		Expiry				
D.V.A No.					Gold □		White		Expiry				
Centrelink Pension/				P	ension		Health Car	e 🗆	Expiry				
	Health Card No.												
Residential Ad	dress									_			
Suburb						State	e		Postcode				
Postal Address						State	e		Postcode				
Phone Number		Mobile:			Hom	ne:			Work:				
Any Known All	ergies												
Email Address													
Occupation													
Next of Kin Name:		Mr Mrs Ms											
		First Name: Last Name:											
	Next of Kin Phone:				Relat	ionsh	ip with Ne	ext of	Kin:				
Emergency Co						Lact	Namo						
Emergency Co	ntact	Mr □ M First Name					Name:	nord	ancy Contac	. .			
Emergency Con Name: Emergency Con	ntact							nerge	ency Contac	t:			
Emergency Co	ntact							nerge	ency Contac	t:			
Emergency Con Name: Emergency Con Phone Number:	ntact	First Name	2:		Relat	ionsh	ip with En		,	t:			
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Emergency Con Name: Emergency Con Phone Number: PARENT OR GUA	ntact	First Name	2:		Relat section	ionsh if chii	ip with En		,	t:			
Emergency Con Name: Emergency Con Phone Number: PARENT OR GUA	ntact	First Name	2:		Relat section Midd Mobil	ionsh if chil le Na le Nu	ip with En	16 ye	,	t:			
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	ENT: Collection of Patients Information and Its Use Ilowing information, tick off each statement 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.									
different ways: for For Billing purposes. Disclosure to other practitioners, regis: Allied health practit requirements e.g., may be sent to you improvement prog	nsent to collect personal information about you and to use the information you pexample (a) For the use of administrative / operational purposes of our medical personal points, including compliance with Medicare and Health Insurance Commission requirer is involved in your healthcare including treating doctors, other doctors, locum metrars, trainees working within our group. Your information, also with other special tioners within or outside this medical practice. (d) To comply with any legislative on the interest of the interest of the interest of the interest of the participate in research and quality rams. The arabout any information or need further information – please talk to your doctors or Practical and any information or need further information – please talk to your doctors or Practical and interest of the information of the information in the inf	oractice. (b) ments (c) dical dists and or regulatory nails) which							
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 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.									
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 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.									
I consent to being contacted by SMS/ phone call / letter related to my Health Issues (you will receive SMS recalls related to your health)									
I have read and understand the information provided above.									
	PLEASE TICK ALL OF ABOVE ONC	E READ							
<u>P</u>	lease present paperwork to reception with Medicare Card and Photo ID								
Signature	nature Patient / Guardian Signature								
Patient ID No Patient ID required for under-age children, <u>Guardian ID must be sighted by staff</u>									
Guardian ID Guardian ID Must be Sighted for under-age children.									
Date									
This section to be completed by staff									
Checked By: Staff NameDate									