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

Appin Medical Centre

PERSONAL DETAILS Patient File No # _____

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

OTHER DETAILS:

Medicare No.		**(IRN) Ref # on card**		**Expiry**	
D.V.A No.		**Gold □**	**White □**	**Expiry**	
Centrelink Pension/ Health Card No.		**Pension □**	**Health Care □**	**Expiry**	
Residential Address					
Suburb		**State**		**Postcode**	
Postal Address		**State**		**Postcode**	
Phone Numbers	**Mobile:**	**Home:**		**Work:**	
Any Known Allergies					
Email Address					
Occupation					
Next of Kin Name:	**Mr □ Mrs □ Ms □** **First Name:**		**Last Name:**		
Next of Kin Phone:		**Relationship with Next of Kin:**			
Emergency Contact Name:	**Mr □ Mrs □ Ms □** **First Name:**		**Last Name:**		
Emergency Contact Phone Number:		**Relationship with Emergency Contact:**			

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		**Relationship to Child**			
Your Medicare		**(IRN) Ref # on card**		**Expiry**	

LIFESTYLE HISTORY

Alcohol	**Drinker □ Non-Drinker □ How often do you drink per week: _____** **How many drinks per week: _____**
Smoking	**Smoker □ Vaper □ Non-Smoker □ No. of Cigarettes you smoke per day:**
Exercise	**Do you do any regular exercise: Yes □ No □ please specify type of exercise** **How Many Days Per Week? Hours Per Week?**

PLEASE TURN OVER TO COMPLETE OTHER SIDE

PRIVACY STATEMENT: Collection of Patients Information and Its Use
(Please read the following 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.

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.	☐
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 ONCE READ--

Please present paperwork to reception with Medicare Card and Photo 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	

This section to be completed by staff

Checked By: Staff Name …… Signature……Date ……

*****PLEASE RETURN COMPLETED FORM TO RECEPTION***
WITH PHOTO ID, MEDICARE CARD & ANY CENTRELINK CARDS**