BIRTINYA MEDICAL CENTRE

PATIENT INFORMATION AND CONSENT

The Information supplied by you, on this form, is covered by the Australian Privacy Principles

Patient details:

(Mr/Master/Mrs/Ms/Miss) ..... FIRST ..... MIDDLE ..... SURNAME

Residential Address .....

Email .....

Date of birth ..... Ethnicity/Nationality .....

Telephone: Mobile ..... Home ..... Work .....

Occupation

.....

To assist with health initiatives, do you identify as being Aboriginal and/or Torres Strait Islander?

YES / NO Please circle: ◊ Aboriginal ◊ T.S Islander ◊ Aboriginal TSI

If you have any of the following cards please present them to the receptionist

◊ Medicare Card ..... Ref Num ..... exp date .....

◊ Veterans' Affairs ..... **White / Gold** exp date .....

◊ Pension Card ..... exp date .....

◊ Health Care Card ..... exp date .....

◊ Commonwealth Seniors Health Care Card ..... exp date .....

For parents or carers of children 16 yrs and under, you will be allocated as Head of Family:

Name ..... DOB .....

Medicare ..... Ref num ..... Exp date .....

Next of Kin :

Name ..... Relationship to you ..... Ph .....

Emergency Contact: (If *As Above* please tick here .....)

Name ..... Relationship to you ..... Ph .....

Do you consent to the following communication:

◊ To receive appointment reminders via SMS? **YES / NO**

◊ To receive Recalls and Reminders via SMS? **YES / NO**

PLEASE SIGN TO AUTHORISE THE ABOVE ..... **Date** .....

How did you hear about our practice: ◊ FRIEND ◊ RELATIVE ◊ YELLOW PAGES ◊ INTERNET ◊ ADVERTISING

General Health Questionnaire

Name .....**DOB** .....

Do you suffer or have you suffered from any of the following?

- ○ Cancer
- ○ Angina, Heart Attack, Bypass Surgery, other heart Disease
- ○ Any Major Accidents
- ○ Diabetes
- ○ Abdominal Complaints
- ○ Liver Disease
- ○ Kidney Disease
- ○ Spinal pain or Injury
- ○ High Blood Pressure
- ○ Depression
- ○ Anxiety or other mental illness
- ○ Asthma/other chronic Lung Disease
- ○ Epilepsy
- ○ Any Surgical Operations
- ○ Other

Comments.....
.....

Are you allergic to or have you had any significant side effects from any medication
.....
.....
.....

Is there a history in your family of any of the above listed illnesses, please record them here
.....
.....
.....

Current Medications & Supplements ie vitamins etc (please list below
.....
.....
.....
.....
.....

Weight ..... Height ..... Waist Measurement .....

Do you smoke, or have you ever smoked? ..... Year commenced .....

How many per day? ..... Year Ceased .....

Do you drink Alcohol? ..... How many standard drinks per day? .....

How many days per week? .....

How many days per week do you exercise .....

What type of exercise do you do .....

- ❖ All information collected forms part of your confidential medical record: this practice is committed to maintaining the confidentiality of your personal Health information.

BIRTINYA MEDICAL CENTRE

Welcome to Birtinya Medical Centre

To enable ongoing care and total quality improvement within this practice, and in keeping with the NPP (National Privacy Policy) we wish to provide you with sufficient information on how your personal health information may be used or disclosed and record your consent or restrictions to this consent.

Your personal health information will only be used for the purposes for which it was collected or as otherwise permitted by law and we respect your right to determine how your personal health information is used or disclosed.

The information we collect may be collected by a number of different methods and examples may include: medical test results, notes from consultations, Medicare and health insurance details, data collected from observations and conversations with you, and details obtained from other health care providers (e.g. specialist correspondence).

By signing below, you (as a patient/guardian) are consenting, that on obtaining your personal health information it may be used or disclosed by the practice for the following purposes:

- Follow up reminder/recall notices for treatment and preventive healthcare
- For accounting procedures and the collection of professional fees.
- The diagnosis and treatment of any health condition, including the communication of relevant information only, to practice staff, specialists and other healthcare providers to ensure quality care is provided.
- Accreditation and Quality Assurance activities are conducted by professionally trained non-treating GP's and other professionally trained and qualified persons eg. General Practice Managers.
- 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.
- For disease notification as required by law.
- For use when seeking treatment by other doctors in this practice.

At all times, we are required to ensure your details are treated with the utmost confidentiality. Your records are very important and we will take all steps necessary to ensure they remain confidential.

I, _____ give my permission for my personal health information to be collected, used and disclosed as described above. I understand only my relevant personal health information will be provided to allow the above actions to be undertaken and I am free to withdraw, alter or restrict my consent at any time by notifying this practice in writing.

Patient Name: (Please Print) _____ DOB _____

Signature: _____ Date: _____

If not Patient signing -Your name (Please Print) _____

Your relationship to patient (e.g. Mother, Father, Guardian) _____

Tel: 0753061201 Fax: 0753551006 ABN