



A Personal Details

Title Mr Ms Mrs Mast Miss Dr Other

Given Name Middle Name Family Name

Preferred Name Date of Birth Gender: Male Female

Medicare Number Ref no. Expiry date Private Health Insurer (if applicable)

Address

Home Phone Work Phone Mobile

I Consent to SMS Reminders

Occupation

B Ethnicity and Culture

Do you wish to identify yourself as: Aboriginal Torres Strait Islander Both

If yes, are you registered for Closing the Gap (CTG)? YES NO

Country of birth (if not Australia) Ethnicity Spoken Language (if not English)

Do you require an interpreter? (ph. 131 450) YES

C Concessions

Pension number HCC Number Expiry Date DVA

D Emergency Contact and Next of Kin (these should be different people)

Name (*Next of kin*) Relationship Phone

Name (*Emergency*) Relationship Phone

E Health Information

Do you have any allergies : No Yes: Do you have: Diabetes Asthma

Women's health: last pap smear

Date (if known) Within last 12 months Within last 2 years Don't know

F Digital Information – HotDoc

To help you manage your appointments, send reminders and forward information you need from us, our practice partners with HotDoc Online Pty Ltd.

HotDoc is an Australian service that provides secure communications (including appointment bookings) between doctors and their patients. To enable these services, we provide HotDoc with some of your personal information including; your name, contact details, DOB and details of the communication we are sending you.

HotDoc respects the privacy and confidentiality of your information and will not sell, exploit or use it for marketing or promotional activities. You may also opt in or out of HotDoc at anytime

G Health Information Collection and Use Consent – please read carefully before you sign

Why and how we collect and use your personal information

As a patient of our medical practice, we require your personal details and a full medical history in order to properly assess, diagnose, treat and be proactive in your health care. We aim to protect the privacy and securely store your health information. You can request a copy of our privacy policy, which includes information about the collection, use and disclosure of your health information.

This practice will use and/or disclose your information for the following:

- Administrative purposes in running our medical practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your healthcare including treating doctors, specialists, nurses and allied health professionals outside this medical practice. This may occur through referral to other medical providers or for medical tests, as well as in the reports or results returned to us following referrals.
- Disclosure to other medical professionals in the practice including locums attached to the practice for the purpose of patient care and teaching.
- For research and quality assurance activities to improve individual and community health care and practice management. Usually information that does not identify you is used but should information that may identify you be required you will be informed and given the opportunity to opt out of any involvement.
- To your employer in the case of employment or pre-employment health checks and to their insurance providers in the case of workers' compensation claims.
- To comply with any legislative or regulatory requirements e.g. notifiable diseases.
- For follow-up recalls and/or reminder letters for treatment and preventative health. This may be done by mail, phone or SMS.(via HotDoc)

You can decline to have your health information used in all or some of the ways outlined above but it may influence our ability to manage your health care to the highest standards.

SIGNATURE

I have read and I understand this form.

By signing below, I consent to the collection and use of my information by the practice for the purposes set out above, subject to any limitations on access or disclosure of which I will notify this practice.

Name

Signature

Date

I am signing on behalf of my child/dependent.

Name of child/dependent

OR

I am unsure and would like to discuss this further with someone from the practice before I sign.

How did you find us? Family/friends Our website Internet Flyer Other