We would like you to be aware before your consultation that we will not prescribe narcotic medications – these are drugs of addiction and subject to State prescribing laws.

PLEASE TICK THAT YOU HAVE READ THIS NOTE [ ]

Mr. Mrs. Miss Ms Master Dr Religious Title Other **PLEASE PRINT CLEARLY**

First Name: ______________________ **Middle Name:** ___________________ **Preferred Name:** __________________________

Surname: _____________________________________ **Date of Birth:** ___/___/____ **Sex:** Male / Female / Transgender

Medicare Card Number: ____________________________ **Reference Number:** _______ **Expiry Date:** ____/____

HCC / DVA / Pension Number: ________________________ **Type of Pension:** ________________ **Expiry Date:** ____/____/____

These Cards MUST be Presented to Reception

Address: ____ Suburb: _______________________ Post Code: ___________

PO Box: ____ Suburb: _______________________ Post Code: ___________

Home Phone: _______________________ Work: ______________________ Mobile: ____________________________

Email: ____

Preferred method of Contact: Home Phone / Work Phone / Mobile / Email / Post / Text Message

Marital Status: Single / Married / Widowed / Divorced / De-Facto / Separated

Cultural Background/Ethnicity (Chinese, German etc.):__________________________

Do you self-identify as being: Aboriginal: Yes/No Torres Strait Islander: Yes/No Not stated: _________

Occupation: _______________________ **Country of Birth:** _______________________ **Year Arrived in Australia:** ___________

Preferred Language Spoken: _____________________ **Health Insurance:** None / Basic Hospital / Intermediate / Top Hospital

Next Of Kin: _________________________________ Ph: ______________________ Relationship to you: ______________________

Emergency Contact: ___________________________ Ph: ______________________ Relationship to you: _____________________

Patient Consent Form

From 21 December 2001 the Privacy Act requires private medical practices to obtain your consent to collect personal information about you. Please read this information carefully and sign where indicated below. The medical practice collects information from you for the primary purpose of providing necessary health care. We require you to provide us with your personal details and full medical details so that we may assess, diagnose, treat and be proactive in your health care needs properly and we will use the information you provide us in the following ways: Recall & reminder system, if you do not wish to be included please let the staff know.

Consent to receive text messages from the clinic: [ ] YES [ ] NO **Consent to receive emails from the clinic: [ ] YES [ ] NO**

Administrative purposes in running our medical practice; billing purposes, including compliance with Medicare & health Insurance Commission requirements; Disclosure to other doctors in the practice including locums for your ongoing care if your usual doctor is not available; Disclosure to others involved in your health care, including treating doctor and specialists outside this medical centre. This may occur through referral to other doctors or medical tests and in the response or results returned to us following referrals. **I assign my right to benefits to the practitioner who rendered this service.**

Disclosure for statistical research and quality assurance activities to improve individual and community health care and practice management. Please be advised that your personal details such as your name address and date of birth are withheld in these situations. Therefore your identity is protected. You may elect for your information to be excluded in such activities. Please place a line through this clause if you prefer your information to be excluded.

I have read the information above and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling patient's information. I understand that I am not obliged to provide any information requested of me but that failure to do so might compromise the quality of health care and treatment given to me.

I am aware of my right to access the information collected about me, except in some circumstances where access might be withheld. I understand I will be given an explanation in these circumstances. I have been advised of the estimated costs in respect of the proposed medical services**. I accept responsibility for payment of this account, including if any nominated insurer does not pay the anticipated costs or declines liability of any injury claims.**

SIGNED (patient, parent or guardian): ____ DATE: ___________________________

PLEASE PRINT NAME: ____