

**A Personal Details**Title  Mr  Mast  Mrs  Ms  Miss  Dr  Other

Given Name

Middle Name

Last Name

Preferred Name

Date of Birth

Gender  Male  Female

Medicare Number

Reference Number

Expiry Date

Postal Address

Home Phone

Work Phone

Mobile

Email Address

**B Concessions**

Pension Number

HCC

Expiry Date

DVA

**C Emergency Contact**

Next of Kin

Relationship

Phone

Emergency Contact Name

Relationship

Phone

**D Ethnicity**

Country of Birth

Year of Arrival in Australia

Ethnicity (Culture, Origin)

Spoken Language

Do you wish to identify yourself as an Aboriginal or Torres Strait Islander?  Yes  NoDo you require an interpreter?  Yes  No If so, language required \_\_\_\_\_**E Health Information**

Allergies or Sensitivities

Medical Conditions or Disabilities

Childhood Immunisation completed?  Yes  NoAre you an overseas student with a BUPA Card?  Yes  No

Year of last tetanus injection

BUPA No.

Expiry Date

**F Authorisation**Would you like to receive reminders about periodic health checks, e.g. diabetic reviews, immunisations, pap smears etc.  Yes  NoAre you happy for us to send you reminders via SMS?  Yes  NoHow did you hear about us?  Word of Mouth  Google  Our Website  Health Engine  Flyer  Other \_\_\_\_\_

Signature

Date

As a patient of our medical practice we require you to provide us with your personal details and a full medical history, so that we may properly assess, diagnose, treat and be proactive in your health care needs.

We aim to protect the privacy and secure storage of 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.

We require your consent to collect personal information about you and to use the information you provide in the following ways. Please read this consent form carefully, and sign where indicated below.

- 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, Allied Health Professionals and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following referrals.
- Disclosure to other doctors in the practice, locums and Allied Health Professionals etc. 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 will identify you be required you will be informed and given the opportunity to “opt out” of any involvement.
- To comply with any legislative or regulatory requirements e.g. notifiable diseases.
- For reminder letters which may be sent to you regarding your health care and management.
- Marketing communications from Westwood Medical Centre (e.g. our email newsletter). Note: we will never provide your personal information to third parties for marketing purposes.

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 provide the best outcome for you.

I have read the information above and understand the reasons why my information must be collected.	<input type="checkbox"/>
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.	<input type="checkbox"/>
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.	<input type="checkbox"/>
I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.	<input type="checkbox"/>
I understand that depending on the age of my child (16 and over) and given my child’s right to privacy, in the clinical judgement of the doctor treating my child I may be prevented from access to information regarding my child’s healthcare.	<input type="checkbox"/>
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.	<input type="checkbox"/>
I consent to receiving marketing communications from Westwood Medical Centre.	<input type="checkbox"/>

**OR**

I am unsure and would like to discuss this further with someone from the medical practice before I sign.	<input type="checkbox"/>
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Patient’s Name

Patient’s Signature

Date

Signed as guardian for child

Name (Printed)