ATHERTON CLINIC – Patient Information Form

Gender: (please circle) Male Female Other

Title: (please circle) Mr Mrs Ms Miss Mst Dr Other

Status: Single Married Widowed Divorced Partner Separated

Surname:

First Name & Middle Name **Preferred Name:**

Date of Birth: / / **Occupation:**

Street Address: **Suburb & Postcode:**

Postal Address: (if different to above)

Home Phone: **Work Phone:**

Mobile No: **Email:** **(email is not encrypted)**

DO YOU CONSENT TO SMS REMINDERS: Yes / No

Do you Identify as: ☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal and Torres Strait Islander ☐ Australian

Country of Birth ________________________________

Do you identify as someone from a culturally and /or linguistic diverse background? ☐ No ☐ Yes - _______________

If yes, do you require an interpreter service? ☐ No ☐ Yes

Medicare No: _____________________________ Ref ______ Expiry Date: ___/______

Does Medicare have your bank details? Yes No

Concession Card (Pensioner/HCC) No: ___________________________ Expiry Date: _____ /___/______

DVA Card__________________ ☐ Gold ☐ White Expiry Date: ____/_____

Private Health Fund: ______________________ Health Fund No: ______________ Reference No: _____

If patient is a minor, who is responsible for payment of the account?

Name: _________________________________ Phone: _________________ Relationship to patient_______________

Next of Kin/ Emergency Contact (*Can be the same person)*

1.Name:____ **Relationship to you**:___________________________

Home Phone: _______________________________________ Mobile Phone: ________________________________

2. Name: ____ **Relationship to you**: ____________________________

Home Phone:____ Mobile Phone: _________________________________

Authorised Representatives *(Can be the same as next of kin)*

1.**Name**:____ **Relationship to you**:______________________________

Home Phone: ____ Mobile Phone:__________________________________

I authorise the above person as an authorised representative

- To collect Scripts/Check on Medications e.g. B12/check on appointment times/ check on availability of results/ if referrals have been sent.
- Act on my behalf regarding the above until this authority is revoked.

I acknowledge that this Authority will remain in force until revoked by myself or my representative/s in writing, or when I appoint a subsequent person to act on my behalf after the date of this authority

Name: ___________________________________ Signature: _________________________ Date: _____________________

Please indicate your preferred method/s of contact by circling one or more of the following. However, you acknowledge that we may need to contact you using any of your contact details that you provide to us from time to time as appropriate.

E.g. Appointment reminders, Clinical reminders, Clinical communications, Health awareness information

Call: Home - Work – Mobile / Mail / SMS / Email – (Please note: Email is no encrypted)

I wish to receive health awareness communication: (e.g. Flu/Measles/Shingles) Yes NO

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YOUR HEALTH INFORMATION

ALLERGY INFORMATION - Do you have any allergies or are you sensitive to drugs or dressings?
☐ No ☐ Yes – provide details: ____

CURRENT MEDICATIONS **–** Please list all your current medications, including complementary and over-the-counter medicines (e.g. homeopathic medicines such as vitamins and minerals etc.)____
____
____
____

YOUR LIFESTYLE HISTORY: *Smoking* ☐ No ☐ Ceased - date____________ ☐ Yes - how many ____ day / ____ week
Alcohol ☐ No ☐ Yes - how many ___ day / ___ week / ___ month
Recreational Drug Use
☐ No ☐ Yes - type_______________ frequency _______________

Patient Consent

Our complete Privacy Policy is available from reception in hard copy.

By signing below, you (as a patient/parent/guardian) are consenting to the collection of your personal information, and that it may be used or disclosed by the practice for the following purposes.

- Administrative purposes in running our general practice and billing purposes, including compliance with Medicare requirements
- Follow-up reminder/recall notices for treatment and preventative healthcare. We contact our patients via phone, SMS to your mobile phone or via mail if SMS is unavailable.
- Disclosure to and with others involved in your healthcare, including treating doctors 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 the referrals.
- Accreditation and quality assurance activities to improve individual and community health care and practice management
- 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 use when seeking treatment by other doctors in this practice.

✓ I understand that I am not obliged to provide information requested of me, but my failure to do so may compromise the quality of health care and treatment given to me.

✓ I am aware of my right to access information collected about me, except in some circumstances where access may be legitimately withheld. I understand that I will be given an explanation in those circumstance.

✓ I understand that if my information is to be used for any purposes other than those set out above, the practice will notify me and request my authority/permission before proceeding.

Your name (Please Print) ______________________________ Signature _____________________________ Date ________________

Your relationship if not the patient (e.g. Mother, Father, Guardian, Carer) ___________________________________

PRACTICE USE ONLY: Witnessed by: (Staff Signature) ____