Medical for Everybody

PATIENT DETAILS

TITLE: ☐ MR ☐ MRS ☐ MS ☐ DR ☐ MASTER ☐ MISS ☐ OTHER

Name: First: Surname: Preferred Name:

Address:

Suburb: Postcode:

Date of Birth: Occupation: Ethnicity:

Do you identify as being of Aboriginal or Torres Strait Islander descent? Aboriginal: **YES** ☐ **NO** ☐ Torres Strait Islander: **YES** ☐ **NO** ☐

Telephone: H: M: W:

Email: Private Health (with extras): **YES** ☐ **NO** ☐

Medicare No: REF (number next to name): Expiry date:

Pension Card No: Expiry date:

Card type (please circle): Pension / Health Care / Commonwealth Seniors / VET Affairs

Do you consent to SMS reminders? YES ☐ NO ☐

EMERGENCY CONTACT

Name: Relationship: Telephone:

☐ Tick this box if this is the same as your next of kin. ☐

NEXT OF KIN

Name: Relationship: Telephone:

PATIENT'S PRIVACY STATEMENT

I agree to allow staff at Medical for Everybody to collect my personal details. I understand this information will be used to assist Medical Practitioners to collect my personal health information

I understand the main reason this information is obtained from me is to assess, diagnose and treat any illness properly and be proactive in my health care. This information may also be used in the following ways:

- Administration in this medical practice
- Billing, including compliance with Medicare and Health Insurance
- Commission requirements for disclosure to others involved in my health care including doctors and specialists outside this practice who may become involved in my treatment
- Disclosure to others for medical defence purposes if necessary
- Enrolment in state/national reminder system eg. pap registry

I agree the clinical record may be used to remind me to return for follow-ups, check-ups and reviews.

I agree my Personal Health Information may be discussed with and/or redirected to other health professionals to ensure best patient care.

I acknowledge that a full statement regarding treatment of my private health information is available on request.

SIGNATURE: DATE: