Douglas Family Medical Centre

Patient Information

Title: **Gender:** M / F **Preferred Name:**

Surname: **Given Names:**

Date of Birth: / / **Cultural Background:** ☐ Aboriginal ☐ Torres Strait Islander ☐ Non Indigenous

Country of Birth: **Ethnicity**:

Marital Status: ☐Sin ☐Def ☐M ☐Div ☐Sep ☐W **Occupation:**

Residential Address				**Postal Address** (If Different)			
Address:				Address:			
Suburb:		Post Code:		Suburb:		Post Code:	

Home: ( ) **Work:** **Mobile:**

Email:

Medicare No. **Reference:** **Expiry:**

Do you consent to receiving SMS reminders? Y / N

Concession Card No: **Type:** Pension/ Health Care Card **Expiry:**

DVA Card: ☐ **White** ☐ **Gold** **Conditions:**

Health Insurance Fund: (if applicable) ☐ Yes ☐ No

_____

Member No: _____

Height: **cm** **Weight:** **kg**

Smoker Status: ☐Non Smoker ☐Ex Smoker ☐Smoker

Alcohol Intake: ☐Nil ☐Occasional ☐Moderate ☐Heavy

Next Of Kin		**Emergency Contact** (different contact)	
Name:		Name:	
Address:		Address:	
Contact No:		Contact No:	
Relationship:		Relationship:	

Do you have an advance Health Directive?
☐ **YES** ☐ **NO**

A document that states your medical & health care treatment/directions. This comes into effect when you are unable to make your own decisions

Do you have any Allergies ?: ☐ **YES** ☐ **NO**

Are you on any over the counter / prescribed Medications : ☐ **YES** ☐ **NO**

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CONSENT

We require your consent to collect personal information about you. Please read this information carefully and sign where indicated below.

We need this information to provide the best quality care. This form complies with RACPG *Standards for general practices.* This means that your personal Health information is kept private and secure, as required by Federal and State privacy laws. If you have any concerns, please leave blank and discuss with the Doctor.

Please notify us promptly of any changes in your contact details.
Accurate contact details help us identify you and your medical records, and allow us to contact you promptly about tests and results.

This medical practice collects information from you for the purpose of providing equality in health care. In the course of the consultation, your doctor may ask your personal details and a full medical history so we may properly access, diagnose, treat and be proactive in your health care needs. This means we may use the information you provide in the following ways:

- 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 and Specialists outside the medical practice. This may occur through referral to other Doctors, for pathology and x-ray, in the reports, or results returned to us following the referrals
- Disclosure to other Doctors in the practice, Locums, Registrars, or Medical students attached to the practice for the purpose of patient care and teaching. Please let us know if you do not want your records assessed for these purposes, and we will note this on your record accordingly.
- Disclosure to a medical legal defence organisation if a medico-legal issue arises
- Pap Smear registry
- Australian Childhood Immunisation Register
- Family cancer register

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 information.

I understand and consent to Douglas Family Medical Centre uploading a shared health summary to My Health Records. If I do not consent, I will inform reception upon arrival before seeing any health practitioner.

I understand and consent to Douglas Family Medical Centre Practice Policies and Procedures.

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 might be legitimately withheld. I understand that I will be given an explanation in those circumstances.

I understand that if my information is to be used for any other purposes other than those set out above, subject to any limitations, access, or disclosure, that I notify the practice.

I understand that if I fail to attend any booked appointment without contacting the practice, I may be charged a cancellation fee. This will be required to be paid at the time of the next consultation.

Signed: _____ Date: ____/_____/_____

Patient's Name: _____ DOB: ____/_____/_____

Medicare Card sighted by reception staff ☐ **YES**