



For Office Use Only

SEDS

EBSS

Personal Information

Mr Mrs Ms Miss Master

Surname: _____

First Name: _____

Middle Name: _____

Date of Birth: ___/___/_____

Gender: Male Female Intersex

Indeterminate Transgender

Do you identify as: Aboriginal Torres Strait Islander

Neither Aboriginal or Torres Strait Islander

Aboriginal and Torres Strait Islander Other

Other (please specify): _____

Country of Birth: _____

Ethnicity: _____

Main language spoken: _____

If not English, do you need an interpreter? Yes No

If yes to above, what language? _____

Do you have any allergies? Yes No

If yes to above, please detail: _____

Medicare Number: _____

Ref number (next to your name) _____

Medicare expiry date ___/___/_____

Do you have a Pensioner Concession Card? Yes No

Card number _____

Card expiry ___/___/_____

Do you have a Health Care Card? Yes No

Card Number _____

Card expiry date ___/___/_____

Do you have private health insurance? Yes No

Health fund name _____

Do you have extras cover? Yes No

Contact Details

Home Phone: _____

Can we leave a message for you at this no.? Yes No

Work Phone (optional): _____

Can we leave a message for you at this no.? Yes No

Mobile Phone: _____

Can we leave a message for you at this no.? Yes No

Can we leave an SMS confirmation for you at this no.?

Email Address: _____

Home Address: _____

Postal Address (if different from home address):

Emergency Contact

Full name: _____

Relationship to you: _____

Address: _____

Phone Number: _____

Mobile Number: _____

Can we contact this person regarding appointments with our service? Yes No

Health Information Collection and Use Consent Form

Please read this consent carefully, and tick or sign where indicated.

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

We aim to collect information directly from you, wherever possible. We may also need to collect information from other health professionals who have treated you. In an emergency we may also need to collect information from a family member, friend, carer or other person who can help us to provide you with the best care.

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.

- Administrative purposes in running our service.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to other health providers in the service, locums etc, attached to the service for the purpose of patient care and teaching.
- Disclosure to other health providers involved in your care.
- For research and quality assurance activities to improve individual and community health care and service management. 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 eg notifiable diseases.
- For reminder letters which may be sent to you regarding your health care and management.

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.

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.

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.

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.

I consent to the handling of my information by the service for the purpose set out above, subject to any limitations on access or disclosure of which I notify third party.

Signature: _____

Print Name _____

I am unsure and would like to discuss this further with someone from the service before I sign.