CONFIDENTIAL INFORMATION TO BE INCORPORATED IN YOUR MEDICAL FILE

Mr/Mrs/Ms/Miss/Other GIVEN NAME: _____SURNAME:_____

POSTAL ADDRESS: _____POSTCODE:_____

HOME: _____WORK: _____MOBILE: _____

EMAIL: _____ DOB: ____/____/_____

DO YOU HAVE ANY KNOWN ALLERGIES?_____

DO YOU HAVE PRIVATE HEALTH INSURANCE? YES / NO

IF YES, WHICH FUND: _____ MEMBERSHIP NUMBER:_____

MEDICARE NUMBER: _____REFERENCE NUMBER: *(before your name)*_____

EXPIRY DATE: _____

PENSION/ VETERANS NUMBER:_____

NEXT OF KIN:_____RELATIONSHIP:_____

HOME:_____WORK:_____MOBILE:_____

REFERRING DOCTORS NAME: _____

ADDRESS: _____POSTCODE: _____

LOCAL GP NAME (if not referring doctor):_____

ADDRESS:_____

This Practice requires your consent to collect personal information about you. Please read this information carefully and sign where indicated.

Why do we collect information?

The information is for the primary purpose of providing quality health care. We need you to provide us with your personal details and full medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. This means we will use the information you provide in the following ways:

- Administrative purposes in running our Practice
- Disclosure to others involved in your health care, including treating Doctors, Specialists and other Health Care Professionals outside this practice. This may occur through referral to other doctors or for medical tests and investigations, in the reports returned to us following the referrals.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure for research and quality assurance activities to improve individual, community health care and practice management. There may be occasions when disclosure of patient information is required for medico-legal purposes.

_____

I have read the information above and understand the reasons why information must be collected. I am also aware that this Practice has a privacy policy on handling patient information.
I understand that I am obliged to provide any information requested of me and that failure to do so might compromise the quality of the health care and treatment given to me.
I am aware of my right to access the information collected, except in some circumstances where access might be legitimately withheld. I understand I will be given an explanation in these circumstances.
I consent to the handling of my information by this Practice for the purposes set out above, subject to any limitations on access or disclosure that I notify this Practice of.
I consent to the retrieval of medical information, including reports and results from medical tests and others involved in my health care including treating Doctors, Specialists, Hospitals, Health Care Professionals and Facilities outside this Practice.

Signed:_____Date:_____