

PATIENT REGISTER

Date: _____ **Mr /Mrs/Mast/ Miss/ Dr/ Other**_____

Full Name: _____ Known as_____

Date of Birth: _____ Male/Female

Medicare Card Number __ __ __ __ __ __ __ __ __ __ __ Ref no: _____ Exp Date: _____

Health Care Card or Pension (circle): _____ Exp Date: _____

DVA Card Number (Gold or Specified): _____ Exp Date: _____

Private Health Fund: _____ Number: _____

Are You Aboriginal or Torres Strait Islander?

NO Yes, Aboriginal Yes Torres Strait Both Aboriginal & Torres Strait Islander

Ethnicity / Cultural Background _____

Home Address_____

Postal Address _____

Email_____

Phone Home _____ Work _____ Mobile _____

Which contact would you prefer us to use: Home / Mobile / Work

Marital Status: Single Married Separated Divorced Defacto Widowed

Occupation: _____ Employer: _____

Country of Birth: Australia Other: _____ Language Spoken _____

How well do you speak English? _____ Do you require an interpreter? _____

What year did you arrive: _____

Next of Kin

Name: _____ Relationship to you: _____

Address: _____Best Contact Number: _____

Emergency Contact Person (Not NOK)

Name: _____ ___Relationship to you: _____

Address: _____Best Contact Number: _____

Payer Details *(for children 17 years and under)*

Name: _____ D.0.B: _____

Address:_____Ph:_____

Medicare Card Number __ __ __ __ __ __ __ __ __ __ __ Ref no: _____ Exp Date: _____

Wt Med the Doctors on Erin Street

PATIENT CONSENT FORM

WT Med the Doctor's on Erin Street requires your consent to collect personal information about you. Please read this information carefully and sign where indicated below.

WT Med the Doctor's on Erin Street collects information from you for the primary purpose of providing quality health care. We may require you to provide us with your Personal Details, Full Medical History, Medicare Number, Private Health Insurance Membership, DVA Number, Health Care or Pension Card Number, Medications and Family History, so that we may properly assess, diagnose, treat and be proactive in your health care needs. This means WT Med the Doctor's on Erin Street will use the information you provide in the following ways:-

- Administrative purposes in running this Medical Practice including billing to comply with Department of Veterans Affairs and Medicare Australia requirements.
- Disclosure to others involved in your health care, including Treating Doctors, Specialists outside this Medical Practice. This may occur through referrals to other Doctors/Specialists, or for medical tests and in the reports of results returned to us following the referrals.
- Disclosure to other Doctors in the practice, Locums, and Registrars attached to the Medical Practice for the purpose of patient care and teaching. Please let us know if you do not want your records accessed for these purposes, and we will note in your patient file accordingly.
- Disclosure for research and quality assurance activities to improve individual and community health care and practice management. You will be informed when such activities are being conducted and given the opportunity to "opt out" of any involvement. The information used for these purposes will be de-identified.
- To take part in the Practice's National, State and Territory Reminder Systems.

I have read the information above and understand the reasons why my information must be collected. I am also aware that WT Med the Doctor's on Erin Street has a privacy policy on handling patient information. I understand that I am not obliged to provide any information requested of me, but that my 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 about me except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.

I understand that there may be costs associated with access to my personal health information. I understand that if my information is to be used for any other purpose than set out above my further consent will be obtained. I consent to the handling of my information by WT Med the Doctor's on Erin Street for the purpose set out above, subject to any limitations on access or disclosure that I notify this practice of.

PATIENT NAME: _____ DOB: _____

PATIENT SIGNATURE: _____ DATE: _____

(Guardian to sign if patient under 18 years) GUARDIAN NAME: _____

Medicare de-identified data collection:

As a quality improvement measure, Medicare is collecting de-identified data of patients. This is to assist with improvements to your quality of care. If you do not wish for this to occur, you have the option to "opt out".

I wish to "opt out" of de-identified data collection for quality improvement.

Name: _____ Signed: _____ Date: _____

Do you authorise anyone to speak on your behalf if we cannot contact you? YES / NO If yes please complete the below authorisation.

Authority to act on behalf of

I_____ Hereby authorise _____

Relationship to you _____to be notified of any medical matters/results on my behalf as required. This authority is to expire on _____

Signature_____ Date _____

The purpose of this form is to inform you and seek your consent to the use and disclosure of your personal information (including health information) in regards to our reminders and notifications systems within our practice.

This general practice is committed to providing our patients with quality health care. As part of our commitment, we have implemented technology solutions to enable communications with our patients via SMS, email & Hot Doc..

In keeping with our obligations under Privacy Act 1988 (Cth) and Australian Privacy Principles and under State and Territory health records legislation, we wish to inform you of the purposes for which we may use your personal information and how we may use and disclose your personal information (including health information). Please refer to our privacy policy or privacy statement for more information generally on the management of personal information (including health information) by this general practice.

In addition to other communications we may send you from time to time, we may send you the following types of communications:

1. ***appointment reminders** – notifications to you to remind you of upcoming appointment dates with the practice as well as allowing you to confirm your appointment;*
2. ***clinical reminders** - notifications to you to remind you to contact the practice to arrange appointments for regular clinical check-ups, medical procedures, immunisations due;*
3. ***clinical communications** - communications to you about your clinical care at the practice such as returned pathology results or clinical messages from the medical practitioner; and*
4. ***health awareness** – communications to you in relation to general health care information and health care services provided by this general practice including notification about changes to our clinic opening hours, and information about health care services provided by this general practice.*

As part of the provision of health care services to you, we will send you appointment reminders, clinical reminders and clinical communications from time to time. We may also send you health awareness information if you have consented to receive such communications below. We may use third party service providers (which may be located outside of this State or Territory) and disclose your personal information (including health information) to them, to assist us in sending you the above communications.

To the extent practicable, we will send you communications via your preferred contact method indicated below. However, you acknowledge that we may contact you using any of your contact details that you may provide to us from time to time as we consider appropriate.

Acknowledgements and Consent

I acknowledge and agree that, in the course of providing health care services to me, the general practice may need to use and disclose my personal information (including any health information) as set out in this form.

I wish to receive health awareness communications (as described above) and I hereby specifically consent to the use of my personal information (including any health information) by this general practice to assess the types of health awareness communication it sends me and specifically consent to receipt of such health awareness communications. ☐

Are you agreeable that WT Med contacts you via the forms of communication as stated below?

Phone ☐ Letter ☐ SMS ☐ App ☐ Email ☐

I acknowledge that the practice will use contact details provided by me (as updated by me from time to time) to communicate with me. To the extent that the mobile number I have provided to this general practice is utilised by more than one patient, I understand and consent that all SMS and phone communications will be directed to that number.

Please complete and sign below if you understand and agree to the acknowledgements and consent set out above.

Patient Name: _____

Parent/Guardian Name (if Patient is under 16) _____

Signature: _____ Date: _____