PATIENT INFORMATION REQUEST

Surname: ______________________ Given Names:__________________________
Title: Master/Mr/Mrs/Ms/Miss/Dr/other (please circle)

Date of birth: ____/____/_______ Occupation: ___________________________

Address: ____

Postal Address (*if applicable*) ____

Telephone: Home: _______________________ Mobile: ____________________
Work: _______________________

Medicare Number _____________________ Ref. (*number next to your name*) _______
Expiry Date: ____/____/____
Pensioner Conc. Card Number ________________ Expiry Date: ____/____/____
Health Care Card Number ______________________ Expiry Date:____/____/____
Dept Veteran Affairs Number ___________________________________
Commonwealth Seniors Card ___________________________________

***If under 18 years*, person responsible for accounts – Name: ______________________**
Address (*if different from above*) ____

Next of Kin Contact Person: Name: _____________________________________
Telephone:________________________________
Relationship to patient: ______________________

Emergency Contact Person: Name: _____________________________________
Telephone:________________________________
Relationship to patient: ______________________

Ethnicity: ___________________ Language spoken at home: _________________
Do you identify as Aboriginal and/or Torres Strait Islander person? Yes / No (*please circle)*

Information about fees
Most healthcare services provided by this practice are covered, in part, by Medicare. We ask that payment of your account is settled at the completion of your consultation. EFTPOS facilities are available and we are happy to send your paid account to Medicare.
Privacy
Amendments to the Privacy Act came into effect in December 2001. As a provider of healthcare services it is important that you are aware of how any personal information collected by this practice is used.
This personal information collected is that deemed necessary to best attend to, and treat the presenting health condition(s). Personal information is primarily used internally within the practice, but sometimes it is used to ensure quality and continuity of health care for you and must be partially or fully disclosed to others outside the organization, depending on the circumstances eg. When referring to a specialist medical practitioner or when requesting blood tests, urine tests, x-rays etc; when itemizing accounts for Medicare.
Freedom of information
All patient files that include personal information, test results etc, are the property of this practice. However, should you choose to visit another doctor at any time, copies of the appropriate files can be forwarded on receipt of your written request. Under no circumstances will this practice provide or divulge personal information without your prior written consent. Please note that a small administration fee may be associated with this service.

Please read and sign your acknowledgement below
I have read and understand all information provided regarding fees, privacy and freedom of information. If a debt collection agency is employed to recover unpaid accounts, additional collection fees will apply.
Name: ______________________ Signature: ____________________ Date: ____________

Please read and sign your acknowledgement below
I have read and understand all information provided regarding assisted registration and agree to being registered for eHealth Record.

Name: ______________________ Signature: ____________________ Date: ____________