Brooke Street MEDICAL CENTRE

# New Patient Details

Woodend Medical Centre Pty. Ltd.

***Please Print***

Surname _____ Mr /Mrs /Miss /Ms *(please circle)*

Given Names_____ Preferred Name _____

Home Address_____

Town _____ Postcode _____

Postal Address _____

Gender: □ Male □ Female □ Other Date of Birth _____/_____/_____

Country of Birth _____

Are you of Aboriginal or Torres Strait Islander origin?

□ Yes, Aboriginal □ Yes, Torres Strait Islander

□ Yes, Aboriginal and Torres Strait Islander □ No

Please indicate any other cultural background/s that could help us properly attend to your needs:

_____

Phone – Home ( ) _____ Phone – Work ( ) _____

Phone – Mobile _____

Do you **consent to SMS** messages being sent to you on your mobile phone? □ Yes □ No

*SMS messages maybe used for things like "Confirming" appointments etc...*

Email address:_____

Medicare No: __ __ __ __ / __ __ __ __ __ / __ (10 digits) Ref # _____ Valid to _____/_____

(Ref #: this is the number you are listed on your Medicare card, next to your name)

Do you have: *(please tick)* □ Health Care Card □ Pension

Card No: _____ Expiry Date _____/_____/_____

DVA No: _____ Expiry Date _____/_____ Card colour _____

Will Brooke St. Medical Centre be your usual General Practice? □ Yes □ No

If no, what is your usual General Practice?_____

**P.T.O**

**Who is your next of kin?**

Name _____ □ Male □ Female □ Other

Date of Birth _____/_____/_____

Phone: Home ( ) _____ Work ( ) _____ Mob _____

Relationship _____

Address _____

**Who should we contact in an emergency?**

*Please **name someone with a different phone number** from your own:*

Name _____ □ Male □ Female □ Other

Date of Birth _____/_____/_____

Phone: Home ( ) _____ Work ( ) _____ Mob _____

Relationship _____

Address _____

**Who is responsible for your accounts?**

Name _____

Relationship _____

Medicare No: _____ Ref # _____ Expiry Date _____/_____

(Ref#: this is the number you are listed on your Medicare card, next to your name)

Date of Birth _____/_____/_____

Postal Address _____

**Sign:** ……..…….…. **Date:** ……

**How did you find out about us?**

Word of mouth ☐ Flyer/Mailbox ☐ Facebook ☐

Newspaper ☐ Internet ☐ Family ☐

Other (please specify) _____

OFFICE USE ONLY

**Data entered by: _____ Date: _____**

**P.T.O**

Brooke Street MEDICAL CENTRE

# CONSENT FORM

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

The Brooke Street Medical Centre collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a 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 medical practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals.
- To contact you (or family members) for the purpose of sending Recalls and/or Reminders eg. to follow up test results, review specific health needs at timely intervals; provide health prevention information; health screens etc..
  We contact patients via SMS, mail or phone call.

Patient information shall not be released to a third party without the expressed consent of the patient.

De-identified patient information from the Practice may be used for audit, accreditation and research purposes.

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I have read the information above and understand the reasons why my information is collected.

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 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 that I will be given an explanation in these circumstances.

I understand that if my information is to be used for any purpose other than set out above; my further consent will be obtained.

I consent to the handling of my information by this practice for the purposes set out above.

**Signed ……..** **Date: ……..**

**Patient Name: ……... Date of birth: ……**
*Please print*