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| **PERSONAL INFORMATION** | | | | | |
| Title: | ☐ Dr ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Mast | | | | |
| Surname/Family Name: |  | | | | |
| First Name: |  | | | | |
| Middle Name: |  | | | | |
| Preferred Name: |  | | | | |
| Date of Birth: |  | | | | |
| **CULTURAL BACKGROUND** | | | | | |
| Are you or your children of Aboriginal or Torres Strait Island origin?  If yes, please specify: ☐ Aboriginal but not Torres Strait Islander origin ☐ Torres Strait Islander but not Aboriginal origin ☐ Both Aboriginal and Torres Strait Islander | | | | | |
| **Country of birth**: ☐ Australian ☐ **Other** – Please specify | | | | | |
| Is English your first language? ☐ Yes ☐ No  If no, do you require an interpreter? ☐ Yes ☐ No  Please specify language if an interpreter is required: | | | | | |
| Address: |  | | | | |
| Postal address if different to above: |  | | | | |
| Home Phone Number: |  | | | | |
| Work Phone Number: |  | | | | |
| Mobile Phone Number: |  | | | | |
| **REMINDER SYSTEM** | | | | | |
| Are you happy to receive SMS reminder? | | | ☐ Yes ☐ No | | |
| Are you happy to receive SMS results? | | | ☐ Yes ☐ No | | |
| Would you like to receive a Recall Reminder via SMS: (i.e. annual health check, pap smears, skin checks, immunisation) | | | ☐ Yes ☐ No | | |
| Email Address: |  | | | | |
| Occupation: |  | | | | |
| Medicare Number: | | | Ref No: | Expiry Date: | |
| DVA Gold/White: |  | | Type: | Expiry Date: | |
| Pension/Concession No: |  | | Type: | Expiry Date: | |
| **NEXT OF KIN DETAILS** | | | | | |
| Name: |  | | | | |
| Contact Number/s: |  | Relationship: | | |  |
| **EMERGENCY CONTACT (if different to Next of Kin)**  **or state as above or none given** | | | | | |
| Name: |  | | | | |
| Contact Number/s: |  | Relationship: | | |  |
| **AUSTRALIAN DEFENCE FORCE** | | | | | |
| Are you registered with ADF Family Health? ☐ Yes ☐ No | | | | | |
| Are you an ex-serving ADF member? ☐ Yes ☐ No | | | | | |
| **HEAD OF FAMILY DETAIL (if new patient is 18 or under)** | | | | | |
| Name: DOB: | | | | | |
| Phone: Medicare No: | | | | | |
|  | | | | | |
| **CONSENT** | | | | | |
| We require your consent to collect personal information about you. Please read this information carefully and sign where indicated below.  This medical practice collects information from you for the purpose of providing equality in health care. During the consultation, your doctor may ask your personal details and a full medical history, so we may properly access, diagnose, treat and be proactive in your health care needs. This means we may 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 healthcare, including treating Doctors and Specialists outside the medical practice. This may occur through referral by email, facsimile or post to other Doctors, for pathology and x-ray, in the reports, or results returned to us following the referrals; * Disclosure to other Doctors in the practice, Locums, Registrars, or Medical students attached to the practice for the purpose of patient care and teaching. Please let us know if you do not want your records assessed for these purposes, and we will note this on your record accordingly; * Disclosure to a medical legal defence organisation if a medico-legal issue arises; * Pap Smear registry; * Australian Childhood Immunisation Register; * Family cancer register.   I have read the information above and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling patient information  I understand that I am not obliged to provide information requested of me, but my failure to do so may compromise the quality of health care and treatment given to me.  I am aware of my right to access information collected about me, except in some circumstances where access might be legitimately withheld. I understand that I will be given an explanation in those circumstances.  I understand that if my information is to be used for any other purposes other than those set out above, subject to any limitations, access, or disclosure, that the practice will notify me.  **I understand that if I fail to attend any booked appointment without contacting the practice, I may be charged a cancellation fee. This will be required to be paid at the time of the next consultation.**  Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ | | | | | |