

Office Use Only

Title:	First Name:	Surname:
Preferred Name:		Date of Birth:
Please Circle		
Non-Indigenous Aboriginal Torres Strait Islander Aboriginal and Torres Strait		
Medicare Number:		Expiry Date:
Medicare Reference Number: eg 1 John Citizen Medicare Reference is ① 2 Jane Citizen Medicare Reference is ②		
Concessions: Please Circle		
None Health Care Card Pensioner Veteran Gold Card Veteran White Card		
Concession Card Number:		Expiry Date:
Private Health Insurance: None Basic Hospital Intermediate Top Hospital		
Residential Address:		
Suburb:		Post Code:
Postal Address: (if different from above)		
Phone Home:	Mobile:	Work:
Email:		
Please Circle		
Single Married Widowed Divorced Defacto Separated		
Occupation:		
Country of Birth:		
Next of Kin:		Contact Phone:
Next of Kin Relationship: Please Circle		
Husband Wife Father Mother Brother Sister Son Daughter Partner		
Current Medications:		
Medicine Allergies:		
Food Allergies:		

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Please Circle			Would you like to quit ?			Yes	No
Non Smoker	Quit Smoking	Smoker					
Please Circle							
Alcohol Consumption:		Daily	Weekly	Monthly	Rarely	Never	
Immunisation History							
Adult Immunisations: Please circle the immunisations you have received							
Hepatitis B	HPV	Influenza	Swine Flu	Tetanus	Whooping Cough		
Childhood Immunisations: Please circle the immunisations your child has received							
2 months	4 months	6 months	12 months	18 months	4 years		
Family History and Health Conditions: Please Circle the conditions that affect you or your family							
Asthma	You	Mother	Father	Not applicable			
Diabetes	You	Mother	Father	Not applicable			
Kidney Disease	You	Mother	Father	Not applicable			
Heart Aliment	You	Mother	Father	Not applicable			
Epilepsy	You	Mother	Father	Not applicable			
Hepatitis	You	Mother	Father	Not applicable			
High Blood Pressure	You	Mother	Father	Not applicable			
Low Blood Pressure	You	Mother	Father	Not applicable			

Please turn the page to view and SIGN the Privacy Notice to Patients
and return form to the the receptionist.

Thank You.

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Privacy Notice for Patients.

To enable ongoing care and total quality improvement within this practice and in keeping with the Privacy Act 1988 and National Privacy Principles, we wish to provide you with sufficient information on how your personal health information and Medical Record maybe used of disclosed and record your consent or restrictions to the consent.

Your personal health information and Medical Record will only be used for the purpose for which it was collected or as otherwise permitted by law and we respect your right to determine how your personal health information and Medical Record is used or disclosed. The information we collect may be collected by a number of different methods and examples may include: medical test results, notes from consultations, Medicare and health insurance details, data collected from observations and conversations with you and details obtained from other health care providers (eg. Specialist correspondence).

By signing below you as a patient/guardian are consenting that on obtaining your personal health information and Medical Record it may be used or disclosed by the practice for the following purposes:

- For communicating relevant information with other treating doctors, specialists or allied health professionals
- For follow up reminder / recall notices by mail and/or telephone (SMS when technology is available to this practice)
- For National/State or territory registers (eg. Immunisation data)
- For State/Territory reminder systems, (eg cervical screening - pap smears reminders or familiar cancer registries).
- Accounting / Medicare / Health Insurance procedures and collection of professional fees.
- Quality Assurance activities such as accreditation
- For disease notification as required by law (e.g. infectious diseases)
- For use by all doctors/nurses/allied health professionals in this group practice when consulting with you
- For legal related disclosure as required by a court of law (e.g. subpoena, court order, suspected child abuse)
- For research purposes (de-identified, meaning you are not able to be identified from the information given)

If you have any concerns or wish to restrict access to your personal health information please discuss these with your doctor or receptionist.

This practice adheres to principles of the RACGP Handbook for the Management of Health Information in Private Medical Practice and has a written policy, which is available to all patients for inspection.

Patient name:	
Signature:	Date:
If signing for the patient please print your name:	
Relationship to Patient eg Mother, Father, Guardian:	

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