Medicare Card: _____ Pension/Health Care Card: _____ Checked ID: ☐Yes ☐No

Ref No: _____ Exp date: _____ Exp date: _____

WELCOME TO OUR SURGERY
COULD YOU PLEASE PROVIDE US WITH YOUR DETAILS?

Have any of your Family members ever been a Patient …….

Title	Dr	Prof	Mr	Mrs	Ms	Master	Miss
Surname							
First Name				**Known As:**			
Date of Birth:							
Street Address							
Suburb and Post Code							
Home Phone				**Work Phone**			
Mobile Phone							
Email	Would you like to be added to our email newsletter ☐ Yes ☐ No						
Occupation							
Preferred Method of Contact	☐ Letter		☐ SMS		☐ Email		
Next of Kin (relationship to patient) (Name and Phone number)							
Emergency Contact (relationship to patient) (Name and Phone number of the person we can contact if needed)							

Martial Status:

☐ Single ☐ Married ☐ De facto ☐ Widowed ☐ Divorced ☐ Separated

To assist with health initiatives - Are you of Aboriginal or Torres Strait Islander origin?

☐ Yes ☐No

Ethnic Background: _____

Country of Birth: ☐ Australia ☐ Other: _____

Do you have any allergies or are you sensitive to drugs or dressings:

☐ No ☐ Yes (If yes please list with reaction if possible) _____

_____

Your Health History - Do you have or had a history of?

☐ Operations ☐ Diabetes ☐ Hypertension

☐ Chronic illness ☐ Cancer ☐ Asthma

☐ Other _____

Social history:

☐ Tobacco: _____ day / week / year commenced _____ or Ceased Smoking - date _____ ☐ Never Smoked

☐ Alcohol: _____ day / week / month (circle the one applicable)

Current Medications (including over the counter medications, vitamins and minerals)

_____

_____

_____

Family History - Has any members of your family had Diabetes, Asthma, Heart Disease, Cancer, Mental Illness, Other (Please list)?

☐ Father ☐ Mother

☐ Brother ☐ Sister

IF YOU HAVE A PENSION CARD / HEALTH CARE CARD or DVA CARD -- PLEASE HAND IT TO OUR RECEPTION STAFF

Health Information Collection and Use Consent Form

North Road Medical Pty Ltd
409 North Road
South Caulfield VIC 3162

As a patient of our medical practice 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.

We aim to protect the privacy and secure storage of your health information. You can request a copy of our privacy policy, which includes information about the collection, use and disclosure of your health information.

We require your consent to collect personal information about you and to use the information you provide in the following ways. Please read this consent form carefully, and sign where indicated below.

- 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 this medical practice. This may occur though referral to other doctors, or for medical tests and in the reports or results returned to us following referrals.
- Disclosure to other Doctors, Hospitals, Chemists, Dentists, Ambulance Service, Royal District Nursing and locums etc.
- For research and quality assurance activities to improve individual and community health care and practice management. Usually information that does not identify you is used but should information that will identify you be required you will be informed and given the opportunity to "opt out" of any involvement.
- To comply with any legislative or regulatory requirements eg notifiable diseases.
- For reminder letters which may be sent to you regarding your health care and management.

You can decline to have your health information used in all or some of the ways outlined above but it may influence our ability to manage your health care to provide the best outcome for you.

Please place ☑ OR ☒ in the boxes provided below:

I have read the information above and understand the reasons why my information must be collected.	☐
I understand that I am not obliged to provide any information requested of me, but failure to do so may compromise the quality of health care and treatment given to me.	☐
I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.	☐
I consent to the handling of my information by the practice for the purpose set out above, subject to any limitations on access or disclosure of which I notify this practice.	☐
OR	
I am unsure and would like to discuss this further with someone from the medical practice before I sign.	☐

Patients Name_____ Date_____/_____/_____

Patient's signature_____

Signed as Guardian for child_____ Name (printed) _____