

**BANGALOW MEDICAL CENTRE**  
CONFIDENTIAL PATIENT DETAILS

TITLE: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ SURNAME: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_

POSTAL ADDRESS: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ MALE/FEMALE (please circle)

PHONE NO (home) \_\_\_\_\_ (work) \_\_\_\_\_ (mobile) \_\_\_\_\_

MEDICARE CARD NO: \_\_\_\_\_

WHAT NUMBER IS IN FRONT OF YOUR NAME ON THE MEDICARE CARD: \_\_\_\_\_

EXPIRY DATE ON MEDICARE CARD: \_\_\_\_\_

DO YOU HOLD ONE OF THE FOLLOWING CARDS – please tick one:

AGED PENSION,  HEALTH CARE CARD,  DEPT. VETERANS AFFAIRS

OTHER CARD – please specify type of card \_\_\_\_\_

CARD NUMBER: \_\_\_\_\_ EXPIRY DATE: \_\_\_\_\_

MARITAL STATUS:  single  married  defacto  separated  divorced  widowed

OCCUPATION: \_\_\_\_\_

ARE YOU OF ABORIGINAL OR TORRES STRAIT ISLANDER ORIGIN:  NO

Aboriginal  Torres Strait Islander  Aboriginal and Torres Strait Islander

**EMERGENCY CONTACT**

NEXT OF KIN \_\_\_\_\_ PHONE NO \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_

IF COMPLETING FOR A CHILD PLEASE COMPLETE THE FOLLOWING DETAILS:

MOTHERS NAME \_\_\_\_\_ PHONE NO: \_\_\_\_\_

FATHERS NAME \_\_\_\_\_ PHONE NO: \_\_\_\_\_

**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 primary purpose of providing quality health care. We require you to provide us with your personal details and full medical history so that we may properly assist, 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. This may include other treating doctors and specialists outside of this medical practice. It may also include other health care professionals such as physiotherapists involved in your treatment. This may occur through referral to other doctors or by referral for medical tests. The report and results of same would be returned to us following the referral.
- ❖ Disclosure to other doctors in the practice, locums, registrars and Research Fellows attached to the practice for the purpose of patient care and teaching. Our reception staff may also be aware of some of your medical information as they may contact you with results or investigations we have ordered.
- ❖ Your doctor is involved in Research Studies, which involve collating medical information for the purposes of auditing and quality assurance. All personal details involved in research and quality assurance is deleted and therefore you will remain anonymous. The activities noted may also involve photographing your x-rays. Again, private details will be deleted. You will be informed when such activities are being conducted and given the opportunity to "opt out" of any involvement.
- ❖ Emergency situations whereby medical officers/hospitals require access to patient notes for treatment purposes.

---

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 any information requested to me, but that my failure to do so might compromise the quality of the 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 I will be given an explanation in these circumstances.

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 this practice for the purpose set above, subject to any limitations on access or disclosure that I notify this practice of.

Patients Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
(Please Print)

Signed \_\_\_\_\_ Date Signed \_\_\_\_\_