CARLYLE MEDICAL CENTRE PATIENT INFORMATION FORM

Title: **Mr. Mrs. Miss. Ms. Master** (Please circle one)	**Surname:** **First name:** **Preferred Name:**
Date of Birth:	**Country of birth:**
Address: .... **Suburb** ..... **Post code**	**Postal address:** (if different from residential)
Phone contact: Home:	**Mobile:** **Work:**
Medicare no: **ref.**	(Beside name) Expiry date:
Pension/Health Care No.	Expiry date:
DVA Gold/ White (please circle)**card no.**	Expiry Date: **Health Cover:** Y/N
Occupation:	**SMS Reminders:** **Yes / No**
Marital Status: (Please circle one) Single	Married Widowed Separated Defacto
Emergency Contact: Name	Relationship to you: Phone no:
Will you be using this practice on a regular basis?	**YES/ NO**
If you answered yes, would you like to have your records forwarded to this practice?	**YES/ NO**
Do you identify yourself as: (please circle) Aboriginal Torres Strait Islander Aboriginal and Torres Strait Islander	Non Aboriginal and Torres Strait Islander Other nationality:_____ Do you require an interpreter:- Yes/No If yes, which language? _____

THIS PRACTICE <u>DOES NOT</u> PRESCRIBE SCHEDULE 8 DRUGS ON THE FIRST CONSULTATION:

<u>Reminder System</u>

Carlyle Medical Centre provides our patients with preventative care and early case detection reminders e.g. Immunisations, annual health checks, skin checks and pap smears.

<u>Did not attend</u>

Carlyle Medical Centre reserve the right to charge a $30.00 fee if I do not attend my appointment without cancelling at least 24 hours prior to when I am suppose to attend.

(Please circle one option) **<u>I CONSENT/ DO NOT CONSENT</u>** to being placed on the recall/reminders system at Carlyle Medical Centre and agree to allow my doctor to follow up on any investigations ordered on my behalf and the surgery staff to contact me to return if required to do so.

<u>Pathology/Investigations</u>

If your doctor orders any investigations for you, it is your responsibility to come in for those results.

<u>Signature</u>: _____ *<u>Date</u>*: _____

Carlyle Medical Centre Health Information Collection and Use Consent Form

As a patient of our medical practice we require you to provide us with your personal details and 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 you to 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.

- Administration purposes in running our 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 through referral to other doctors, or for medical tests and in reports or results returned to us following referrals
- Disclosure to other doctors in the practice, locums etc attached to the practice for the purpose of patient care and teaching
- 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 would 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 e.g. notifiable diseases
- For reminder letters whish may be sent to you regarding your health care and management

You can decline to have your health information used in all or some ways outlined above but it may influence our ability to manage your healthcare to provide the best outcome for you. If unsure and would like to discuss this matter further with someone from the medical practice before you sign please speak to a staff member.

Declaration:

- 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 by me, but failure to do so may compromise the quality of health care and treatment given to me
- I am aware of my rights to access the information collected by me, except in some circumstances where access may be legitimately withheld. I will be given an explanation in these circumstances.
- I understand that if my information is 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

Patients Name ..... Guardians Name .....

Signature..... Date .....