



SMS Reminders are now used here!

You will now be contacted via SMS for certain appointment types, recalls, and preventative health information. Please see our receptionist if you wish to opt out of any of these services.

Title: _____ Surname: _____ Given Name: _____

Date of Birth: ____ / ____ / ____ Birth Sex: Male Female Gender Identity: _____

Ethnicity: Australian Aboriginal Torres Strait Islander Other: _____

Address: _____ Suburb: _____ Postcode: _____

Phone numbers: Home _____ Work _____ Mobile _____

Medicare No: _____ Ref: _____ Expiry Date: _____ / _____

Health Care Card No: _____ Expiry Date: _____ / _____ / _____

Pension Card No: _____ Expiry Date: _____ / _____ / _____

DVA No: _____ White Gold NCACCH HAC No: _____ Ext: _____

Next of Kin: _____ Emergency Contact: _____

Phone No: _____ Phone No: _____

Relationship: _____ Relationship: _____

Privacy Act Amendment (2000)

We value your privacy. All information about you, held in this practice, is kept in the strictest confidence. With the introduction of the Privacy Act Amendment (2000) in December 2001 we remain committed to protecting your privacy and are now asking for your express consent for the use and disclosure of your personal health information in the course of your health care. This consent allows those involved in your health care access to the information necessary to continue the high-quality standard of health care.

I consent to the use of my personal health information by the above named practice and other health providers involved in my medical treatment and health care.

I consent to the disclosure of my personal health information by the above named practice to other health providers directly or indirectly involved in my personal health care or medical treatment. I consent to the transfer of my de-identified health information to third parties for quality improvement audits and professional development activities.

In addition, if I am registered with the North Coast Aboriginal Corporation for Community Health (NCACCH), I agree for my GP to share relevant information with NCACCH to assist NCACCH in continuing to deliver quality health care. I understand the information will be treated in strict confidence and will not be used for any other purpose that is not related to NCACCH services.

Personal Declaration:

Name: _____
Signature: _____
Date: ____ / ____ / ____

Declaration on behalf of another person unable to comprehend or complete a personal declaration:

Signed for & on behalf of the patient.
Name: _____
Signature: _____
Date: ____ / ____ / ____

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