Landsborough MEDICAL CENTRE lmc

LANDSBOROUGH & MOOLOOLAH MEDICAL CENTRE

Patient Details Form

SMS Reminders are used at our practice. You will 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 or for more information.

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_____

Email Address: *(used for eScripts only)* _____

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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