

SMS Reminders are used at our practice. You will be contacted via SMS for appointments, 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: \_\_\_\_\_

Medicare No: \_\_\_\_\_ Ref: \_\_\_\_\_ Expiry Date: \_\_\_\_\_ / \_\_\_\_\_

Health Care Card No: \_\_\_\_\_ Expiry Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Pension Card No: \_\_\_\_\_ Expiry Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

DVA No: \_\_\_\_\_  White  Gold

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.

**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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