

258 Shannon Avenue

Geelong West 3218

Phone: 03 5223 9999

Fax: 03 5223 9955

**PATIENT CONSENT**

We require your consent to enable us to collect and handle personal information about you.

Please read the privacy information carefully, and sign where indicated below. If you have any concerns or queries about this, feel free to ask us for further explanation.

The Medical Centre collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose and treat you and be pro-active 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 requirements
* Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, for medical tests and in the reports or results returned to us following the referrals
* Disclosure to other doctors in the practice, locums and Registrars attached to the practice for the purpose of patient care and teaching. Please let us know if you do not want your records accessed for these purposes and we will note your record accordingly
* Disclosure for the research and quality assurance activities to improve individual and community health care and practice management.
* We have closed circuit TV (CCTV) for your safety in waiting rooms and hallways, cameras are clearly visible

I have read this practice’s privacy policy and understand why collecting information about me is necessary. 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 of me. I also understand that failure to provide this medical practice with all the information it needs may restrict the practices’ ability to provide the quality of health care and treatment that I want.

I am aware that I have a 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 in the Privacy Policy, my further consent will be obtained.

I consent to the handling of my information by this practice for the purposes set out in the privacy policy handed to me today, subject to any limitations on access or disclosure that I notify this practice of.

I acknowledge that I have read the Privacy Policy before signing this consent and any aspects of the Policy that I at first did not understand have been clarified by a member of the staff of the Practice.

Health E Medical Centre is a private billing practice. I understand there will be out of pocket fees associated with services provided:  **YES**  **NO**

|  |  |  |  |
| --- | --- | --- | --- |
| *Name of Patient:* |  | | |
| *Date of Birth:* |  | *Date:* |  |
| *Signature:* |  | | |
| *Witness:* |  | | |

**Patient Registration**

Title: Miss Ms / Mrs / Mst / Mr / Other …………

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | | |
| Address: |  | | |
| City/Suburb: |  | P/Code |  |
| D.O.B: |  |  |  |

Phone: Home:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Private Health Insurance Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Approve SMS for**: Please answer YES or NO to each option below.

\* Appointments Y N \*Clinical Communication (Results & Clinical Messages) Y N

\*Clinical Reminders Y N \* Health Awareness (Leaflets & Database search) Y N

\*Is the mobile number to be used for other patients Y  N 

If Yes (to other patients): PatientName/s:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship:

**Next of Kin:**

Miss / Ms / Mrs / Mst / Mr

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | | |
| Phone: |  | Alternate Phone: |  |
| Relationship: |  | | |

**Emergency Contact (cannot be the same as Next of Kin)**

Miss / Ms / Mrs / Mst / Mr

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | | |
| Phone: |  | Alternate Phone: |  |
| Relationship: |  | | |

**Patient Photo ID sighted: Yes No **

**Allergies Reaction Nil Known**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­

**Past Medical History**

**Condition Date Diagnosed**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History**

Aboriginal Torres Strait Islander Aboriginal/Torres Strait Islander

Australian Other Ethnicity: (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother alive? Yes No Age of Death: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cause of Death: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father alive? Yes No Age of Death: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cause of Death: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother: Diabetes Hypertension Heart Disease Stroke

Colon Cancer Depression Breast Cancer

Father: Diabetes Hypertension Heart Disease Stroke

Colon Cancer Depression

**Other:**

Relationship – Maternal / Paternal Condition

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History**

Marital Status: Single Married Defacto

Separated Divorced Widowed

Elite Athlete: Yes No

Breast Feeding: Yes No

Accommodation: Own home Relative home Other private home Hostel Nursing home Homeless

Rental

Lives With: Spouse Relatives Friends

Alone

Have Carer: Yes No

Is Carer: Yes No

**Carer Details**

Miss /Ms /Mrs/Mst/Mr

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/Suburb: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ P/Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alternate phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Occupation**

Retired Previous Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Workplace name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Exposure to: Asbestos Dust Radiation Animals

**Alcohol**

Non Drinker

Current Alcohol Intake

Days per week: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Standard drinks per day: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Description: Beer Wine Spirit

Past Alcohol Intake

Nil Occasional Moderate Heavy

Year Started \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year Stopped \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Tobacco**

Non Smoker Ex-Smoker Smoker

Smoking type: Cigarettes Cigar Pipe

How many per day? \_\_\_\_\_\_\_\_\_\_\_\_\_

Year Started? \_\_\_\_\_\_\_\_\_\_\_\_\_

Year Stopped? \_\_\_\_\_\_\_\_\_\_\_\_\_

Past Smoking history: Light Moderate Heavy