SOUTHEND MEDICAL CENTRE

245 HAMPTON STREET HAMPTON 3188
Phone: (03) 9598 7688 Fax: (03)9521 9289
ABN 72 446 901 724
Email: info@southendmedical.com.au

Welcome to Southend Medical Centre

This complete medical history is important for you to obtain good health care. Please feel free to discuss with the doctor if you are unsure of anything or cannot write it down. As you are providing us with health information please also read and sign the consent form on the reverse side of this form to allow us to collect and use your health information.

Personal Details

Last Name:_____ First Name:_____Middle Name: _____

Date of Birth:___/___/___ Male / Female (please circle) Mr. Mrs. Miss Master Ms. Dr. Other ……. (circle)

Marital Status (circle): Single, Married, Engaged, Divorced, De facto, Have a partner, Widowed.

Address:_____ Suburb:_____Postcode: _____

Phone (Home):_____(Work):_____(Mobile):_____

Due to privacy issues, are you agreeable to us confirming/contacting you, including SMS reminders for appointments, on any of the above telephone numbers? Yes / No

Medicare number:_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Expiry _ _ _/_ _ _ PRN No. _____

Pension number:_ _ _ _ _ _ _ _ _ _ _ _Expiry:_ _ _/_ _ _ Veterans' Affairs: _ _ _ _ _ _ _ _ _ _ _ _ _ Expiry:_ _ _/_ _ _

Health Care Card: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Expiry:_ _ _/_ _ _

Private Health Fund? Yes / No Fund Name: _ _ _ _ _ _ _ _ _ _ _ Membership number: _ _ _ _ _ _ _ _ _ _ _

Email: _____@_____

Current Occupation:_____ or School _____Year_____

Do you have a current Workcover claim? Yes / No Insurance company: _

Claim number: _

Employer: _ Address: _

Are you of Aboriginal/Torres Strait Islander Origin? : Yes / No Aboriginal □ Torres Strait Islander □ Both □

Cultural background (eg Mediterranean, etc) _

Country of birth: _

Is English your first language? Yes / No If not do you require an interpreter: Yes / No

Please specify language:_ _

Emergency contact/Next of Kin: _____ Relationship to patient: _____

Phone number(s): _____ _____ _____

Previous Doctor:_____ Address:_____

Other family members attending this practice: _____

Any custody issues?_____

Person Responsible for Account: _____

Address:_____ Suburb:_____Postcode: _____

Phone Number :_____ Payment in full is requested on the day of consultation.

PLEASE TURN OVER THIS PAGE AND FILL IN CONSENT FORM.

Thank you

Health Information Collection and Use Consent Form

Southend Medical Centre requires your consent to collect personal information about you. All persons accessing your personal health information are bound by confidentiality. Please read this consent form carefully, tick the appropriate boxes and sign where indicated below.

This Medical Practice collects such information for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history to allow us to properly assess, diagnose, treat and advise on all your health care needs. Please place a tick in the following boxes if you consent for this information to be used by the Practice in the following ways:

☐ I give my permission for my personal health information to be used for administrative purposes to assist in the running of Southend Medical Centre, including disclosure to others involved in my healthcare, such as treating doctors and specialists within and outside the Medical Practice. This may occur through referral to others Doctors, or for medical tests and in the reports or results returned to my doctor following referrals.

☐ I give Southend Medical Centre permission to direct bill Medicare/Department of Veterans' Affairs electronically as we do not print out patient assignment forms to save paper.

☐ I give my consent for disclosure for research and quality assurance activities to improve individual, community health care and practice management. This may occur when the Practice incorporates patient health records into de-identifiable patient information to transfer to a third party, normally used for quality improvement projects. De-identifiable patient information cannot be traced back to the individual.

☐ I give my contact for my personal health records to be used for identifiable patient health information. This may occur when the Practice participates in research activities on behalf of a university as part of professional development activities to be collected. Identifiable patient information can possibly be traced back to the individual. This includes clinical audits which form part of our Doctor's ongoing training that involves de-identifiable clinical information onto relevant companies including; drug companies, government agencies.

☐ I give my consent to the presence of a third party to be present during my consultation. This may include a Practice Nurse or medical student.

☐ I give my consent to be part of the Practice's National, State and Territory recall and reminder systems. You may be sent reminder letters, SMS or telephoned to help maintain your health care needs when appropriate. This includes National/State/Territory reminder systems/registers.

☐ I give my consent to release results to you and/or your designated relative/carer.
Relative/carer name:……

☐ I am aware of my rights to access the information collected about 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 to be used for any other purpose other than set out above, my further consent will be obtained.

I understand by ticking the relevant boxes above that the Practice is authorised on my behalf to use my relevant personal health information and I am free to withdraw by consent at any time by verbal or written notification.

OR	
I am unsure and would like to discuss this further with someone from the medical practice before I sign.	☐

Patient's Name:_____ Date_____/_____/_____

Patient's signature:_____

Signed as Guardian for child:_____ Name (printed) _____