

Patient Information Form & Privacy Statement

We are committed to providing our patients with the best care. To do this it is essential that your health record is kept up to date and accurate.



MANLY VILLAGE MEDICAL

PERSONAL DETAILS:

TITLE	<input type="checkbox"/> Dr <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Miss <input type="checkbox"/> Mast <input type="checkbox"/> Other		
FIRST NAME		MIDDLE NAME	
SURNAME		PREFERRED NAME	
Date of Birth		Sex:	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other
Ethnicity? <input type="checkbox"/> Australian <input type="checkbox"/> Other (please specify):			
Do you identify as Aboriginal and/or Torres Strait Islander? <input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander			

Medicare No.		Position on card		Expiry	
D.V.A No.		<input type="checkbox"/> Gold <input type="checkbox"/> White		Expiry	
Pension Card No.				Expiry	
Residential Address					
Suburb		State		Postcode	
Postal Address		State		Postcode	
Phone Numbers	Home:	Mobile:	Work:		
Do you consent to SMS reminders? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you consent to SMS Recall & Test Reminders? (No health info. Included in SMS) <input type="checkbox"/> Yes <input type="checkbox"/> No				
Email Address	Would you like to subscribe to our monthly newsletter? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Occupation					
Next of Kin (NOK)					
Next of Kin Phone:	Relationship (NOK):				
Emergency Contact Name					<input type="checkbox"/> Same as NOK
Emergency Contact Phone Number					<input type="checkbox"/> Same as NOK

PARENT OR GUARDIAN DETAILS (Please complete this section if child is under 17 years of age)

TITLE		FIRST NAME		MIDDLE NAME	
SURNAME:				PREFERRED NAME	
Date of Birth				Relationship	
Your Medicare			Position on card		Expiry

PRIVACY STATEMENT

Your Medical Record is a Confidential **Document**. It is the policy of this Practice to maintain security of personal health information at all times and to ensure that this information is only available to authorised members of staff. This information is collected in **accordance** with the National Privacy Principles and is used to manage your health care. If you wish to view a copy of our Privacy Policy, please ask one of our Reception staff.

I, _____, understand and consent to the above Privacy Statement.

Signed: _____ Date: _____

HOW DID YOU FIND ABOUT US?

- Word of Mouth Google Online Booking Street Signage Patient at previous practice (Bay Tce)
 Yellow Pages Facebook Letterbox Mailout/Flyer Newspaper Promo Other (Please specify) _____

Visit our website: www.manlyvillagemedical.com.au & "Like" us on FaceBook for Healthy Updates