

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/Health Care 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	Relationship (EC):				

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. By signing this form, if your consultation is Bulk Billed you agree to assign your right to benefits to the Practitioner who rendered the services. If you wish to view a copy of our Privacy Policy, please ask one of our Reception staff.

Our practice uses MyHealthRecord to foster continuity of care and a greater therapeutic relationship with our patients. A Shared Health Summary may be uploaded to your MyHealthRecord after discussion with your doctor, or where appropriate. Please advise your doctor, if you have any objections to this.

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

Signed: _____ Date: _____

PLEASE RETURN THIS FORM TO RECEPTION ONCE COMPLETED

HOW DID YOU FIND ABOUT US? (please tick)

- Word of Mouth Google Online Booking Street Signage Patient at previous practice (Bay Tce)
 Community Leader Newspaper Facebook MVM Mini Expo Other (Please specify) _____

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