Churinga Medical Centre Details updated Form

Title (Please circle) Mr. Mrs. Ms. Mast. Miss

Surname ..... First Name .....

Date of Birth .....

Gender (Please circle) Male / Female / Not Stated / Intersex / Transgender / Other

Are you Aboriginal or Torres Strait Islander YES / NO (Please Circle?)

Aboriginal ◯ Torres Strait Islander ◯ Aboriginal & Torres Strait Islander ◯

Address .....
Postcode …….

Email .....

Home Phone .....

Mobile Phone..... Do you wish to receive SMS appointment and recall reminders? Y / N

Medicare Number ..... Expiry Date..... Reference No. ….....

DVA Gold / White (Please circle) ..... Expiry Date.....

Pension Number ..... Expiry Date.....

Health Care Card Number ..... Expiry Date.....

Country of Birth .....

Next of Kin – Name.....
Phone …….

Relationship.....

Transport Accident – Complete if relevant

Date of Accident …….. Claim Number …….

WorkCover – Complete if relevant

Date of Accident …… Name of Employer ……

Employer
Address ……

Employer
Email ……

Insurance Company …… Claim No …….

PLEASE NOTE WE ARE A PRIVATE PRACTICE, WE ONLY BULK IF YOU ARE ON A PENSION, HEALTH CARE CARD OR CHILDREN UNDER 18 WHO ARE STILL STUDENTS

Your health:

Do you have any allergies, or are you sensitive to drugs, foods or dressings: Please circle Yes / No

If Yes, drug name and
reaction.....

.....

Country of origin / Ethnicity ……

Do you suffer from any of the following (Please circle)

Diabetes Type 1/Type 2 Asthma Heart Disease Cancer Stroke

Anxiety/Depression Mental Illness Other? Please Specify:……..

Hypertension (High blood pressure) High Cholesterol Blood disorders

Do you have any other chronic illness? Yes / No Height:…….. Weight:……..

If Yes, please give
details ……
……

Please list any previous operations / injuries / hospitalisations
Year ……
……..

Family History: Have any members of your family had :

Diabetes Asthma Heart Disease Cancer Stroke Mental illness

Hypertension (High blood pressure) High Cholesterol Blood disorders

Your Social History:

Marital Status (Please circle) Single / Married / Partner / De Facto / Divorced / Widowed

Living Arrangements (Please Circle) Alone With Family/Spouse/ Retirement Village/Other – Please Specify

Occupation …….

Do you smoke (Please circle) Yes / No

Tobacco: .....day / week (or ceased smoking) - date .....

Do you drink (Please circle) Yes / No

Alcohol: …….. glasses day / week / month (Please circle)

Female Patients: When did you last have: Pap smear ..... Breast Check.....
Male Patients: When did you last have an overall check? ……

Reminder System: Our practice is committed to preventative care. We seek your permission to be included on our reminder system. We may issue you with a reminder notice offering you preventative health services appropriate to your care. If you do not wish to be part of this system please advise your doctor.

Privacy: Your personal information is kept secure with access to Doctors and staff necessary within our practice. Your personal information is only disclosed to a third party where you could reasonably expect such disclosure. i.e. Specialist Referral. See Privacy Statement on display.

Your Signature: Date .....

Health Information Collection and Use Consent Form

Churinga Medical Centre, 465 Mount Dandenong Road, Kilsyth 3137 Telephone: 9722 9888 Fax: 9722 9933

As a patient of our medical practice we require you to provide us with your personal details and a full medical history, so that we may properly assess, diagnose, treat and be proactive in your health care needs.

We aim to protect the privacy and secure storage of your health information. You can request a copy of our privacy policy, which includes information about the collection, use and disclosure of your health information.

We require your consent to collect personal information about you and to use the information you provide in the following ways. Please read this consent form carefully, and sign where indicated below:

- Administrative purposes in running our medical practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your healthcare including treating doctors and specialists outside this medical practice. This may occur though referral to other doctors, or for medical tests and in the reports or results returned to us following referrals.
- Disclosure to other doctors in the practice, locums etc. attached to the practice for the purpose of patient care and teaching.
- For research and quality assurance activities to improve individual and community health care and practice management. Usually information that does not identify you is used but should information that will identify you be required you will be informed and given the opportunity to “opt out” of any involvement.
- To comply with any legislative or regulatory requirements e.g. notifiable diseases.
- For reminder letters which may be sent to you regarding your health care and management.

You can decline to have your health information used in all or some of the ways outlined above but it may influence our ability to manage your health care to provide the best outcome for you.

I have read the information above and understand the reasons why my information must be collected.	
I understand that I am not obliged to provide any information requested of me, but failure to do so may compromise the quality of health care and treatment given to me.	
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 consent to the handling of my information by the practice for the purpose set out above, subject to any limitations on access or disclosure of which I notify this practice.	

OR

I am unsure and would like to discuss this further before I sign.	

**** I consent to my information being uploaded to the 'My Health ' portal : YES NO Please circle ****

Patient 's Name: ……..……. Date: ….....……

Patient 's signature: ……..……...……

Signed as Guardian for child:
Name: (printed) ….....……