**PATIENT DETAILS FORM**

Title: First & Middle Names:

Surname: DOB:

Address:

Postal Address:

Email Address:

Home phone: Mobile:

NOK: Relationship:

Can we contact them if we can't reach you? **Yes No** NOKPhone:

Medicare Number: Ref. no: Expiry Date:

Private Health Insurer: Member number:

Veteran Affairs (DVA): Colour:

GP’s Name & Clinic Details:

Please list names and addresses of **current** and **relevant** doctors, GPs, surgeons, etc, involved in your care, who need to be included in correspondence from consultations and procedures.

CONSENT TO COLLECT PATIENT INFORMATION

This medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. We will use the information you provide in the following ways:

1. Administrative purposes in running our medical practice.
2. Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
3. Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice as   
   advised by you.

I am aware of my right to access 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 I am not obliged to provide any information requested of me but that my failure to do so might compromise the quality of the health care and treatment given to me.

I understand that if my information is to be used for any purpose other than the above, my consent will be sought.

I consent to the handling of my information be this practice for the purpose set out above, subject to any limitations on access or disclosure of which I may notify this practice.

Signature of Patient:

Name: Date: