The Health Care Centre
PROVIDING MEDICAL AND ALLIED HEALTH CARE
17 Kialla Road Crookwell 2583

PATIENT DETAILS FORM

DATE: / /

Please complete the following information and return to our reception staff

Mr/Mrs/Miss/Ms/Mast/Other: _____ Family Name: _____ Given Name: _____

Middle Name: _____ Preferred Name: _____ Date of Birth____/____/____

Sex: ☐ M ☐ F: ☐ OTHER:_____ Religion: _____ Occupation: _____

Ethnicity: **1**. ☐ Australian, non-indigenous: **2**. ☐ Aboriginal but not Torres Strait Islander: **3.** ☐ Torres Strait Islander but not Aboriginal: **4.** ☐ Both Aboriginal and Torres Strait Islander
Are you registered for Closing The Gap? – (The Program applies to prescriptions for PBS General Schedule medicines only). ☐ Yes ☐ No If **No** would you like us to register your name for this program? ☐ Yes ☐ No
☐ **5.Other** (Please specify) _____

Country of Birth: _____

Residential Address: _____

Postal Address (if different from above):_____

Phone Numbers: Home: _____ Work: _____ Mobile:_____
Preferred contact number: ☐ Home ☐ Work ☐ Mobile
Email address: _____

Medicare No: __ __ __ __ __ __ __ __ __ __ / __ Expiry Date: __ / __

Person listed as number 1 on your Medicare Card: _____
Concession Cards: ☐ Health Care Card ☐ Pension Card ☐ C'Wealth Senior's Card ☐ DVA Card

Card number: __ __ __ __ __ __ __ __ __ __ Expiry: - __ /__ /_____ (Please present card to receptionist)

Private Health Insurance: Fund Name_____ Policy Number_____
Usual Doctor: ☐ Dr. Heidi Ehmann ☐ Dr. Johanna Kovats ☐ Dr. Rebecca Scott ☐ Dr. Jenna Iwasenko

☐ Other_____

Next Of Kin Details

Name: _____ Address: _____

Phone No: _____ Alternate Phone No: _____ Relationship: _____

Emergency Contact Details Or tick to use Next of Kin details ☐

Name: _____ Address:_____

Phone No: _____ Alternate Phone No: _____ Relationship: _____

→ → →→ *PTO to complete information*

Office Use Only											
Entered	Date	Intitial	Checked	Date	Initial	Scanned	Date	Initial	Nurse	Date	Initial

HOW WOULD YOU LIKE THE PRACTICE TO COMMUNICATE WITH YOU?

(a)Would you like to receive test results via Email? □ Yes □ No (Please bear in mind that the email address supplied should be private to you and information contained in the email may also be compromised if it is not secure).

(b)Do you consent to SMS appointment reminders and clinical recalls? □ Yes □ No

(c)If you are unable to receive SMS appointment reminders, do you give permission for an appointment confirmation message to be left at your household? □ Yes □ No

(d) Our practice uses a reminder system to help you maintain your health. The practice sends reminders by post, email, telephone or SMS for procedures such as vaccinations, Pap tests and other health reviews
I consent to being contacted with reminders to help me maintain my health □ Yes □ No

(e)Do you require the services of a language interpreter? □ Yes □ No

(f)Do you require assistance with reading or understanding medical terminology? □ Yes □ No

(g)Do you give permission for information to be given to other health care providers e.g. hospital, specialist doctor, podiatrist, psychologist, pharmacist in the course of your care? This information may be sent via email. □ Yes □ No

(h) Research – Do you give consent to disclosure for research and quality 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.)Declining to participate in research will not affect the care you receive at this practice.

□ Yes □ No

ABOUT YOUR HEALTH

Do you have any of the special needs listed below?

Hearing impairment □ Yes

Vision impairment □ Yes

Physical impairment □ Yes

Other □ Yes Please advise: _____

Allergies and medicines

List allergies and intolerances to medications	Describe your reaction

Signed_____ Dated___ / ___ / ___

******* ***Please see our attached privacy policy for your information. This is for you to keep*** ********

PRIVACY ACT 2001

PATIENT CONSENT TO COLLECT AND DISCLOSE INFORMATION

The Privacy Act requires medical practitioners to obtain consent from their patients to collect, use and disclose that patient's personal information.

COLLECTION OF YOUR PERSONAL INFORMATION

This means that we will collect information that is necessary to properly advise and treat you. The information will usually be collected directly from you. On some occasions it may be necessary to obtain the information from other sources, for example: hospitals, other medical practitioner and or health care providers. Both our medical practitioners and practice staff may take part in the collection of this information. In the case of an emergency we may need to collect personal information from relatives or other sources where we are unable to obtain consent.

SECURITY OF INFORMATION COLLECTED

Your information may be held in a variety of ways. Most commonly, your information may be held as a paper medical record, and / or an electronic medical record forming part of a secure computerized database. Some information may also be held in the form of an image including x-ray or photograph. We follow strict rules and policies regarding the secure storage of personal information in all formats in order to protect your information from unauthorized access, loss or other misuse.

DISCLOSE AND USE OF INFORMATION

With your consent, the practice staff will use and disclose your information for purposes as shown below.

- To other treating health services, hospitals or medical specialists involved in your care and treatment. Our Practice has the facility to upload your Patient Health Summary to My Health Record, via secure service. This will enable the providers listed above to also have access to this information if required. For more detailed privacy information, please refer to the following internet address: www.mythealthrecord.gov.au.
- In order to process pathology tests, x-rays, and so on
- To contact you for feedback on the services you have received from us to help us evaluate and improve our services
- For billing and debt recovery
- To students and other staff for training purposes
- To other health services and authorised third parties to help prevent a serious and imminent threat to someone's life, health or welfare, such as in an emergency
- To claims managers and associated persons for the purpose of managing a complaint, legal action, or claim brought against a treating health professional
- For purposes relating to the operation of The Health Care Centre and treatment of our patients, including funding, planning, safety and quality improvement activities

If you do not wish for us to collect, use or disclose certain information about you, you will need to tell us and we will discuss with you any consequences this may have for your health care.

The law also allows or requires for your personal health information to be disclosed to other third parties, for example:

- To State and Commonwealth government agencies for statutory reporting purposed, such as to report notifiable diseases
- To researchers for public interest research projects as approved by a Human Research and Ethics Committee
- To other health services or law enforcement agencies, such as the Police, if you provide us with information relating to a serious crime, including assault, domestic violence, child abuse, and so on
- To comply with a subpoena or search warrant if your personal information is required as evidence in court

ACCESS TO YOUR INFORMATION

You are entitled to access your own Health Records at a time convenient to the practice. We ask that your request be in writing. We may impose a fee for photocopying and compiling a copy of your records. Where you dispute the accuracy of the information we have recorded, you are entitled to correct that information.

Access may be denied if the release of information is not in the patient's best interest or involves litigation.

CONSENT

Your consent is implied for The Health Care Centre to collect, use and disclose personal information as outlined above. You are entitled to access your own Health Records with a written request. You may withdraw your consent to use and disclose your personal information (except where legal obligations must be met).

For Aboriginal and Torress Strait Islander people who want to register for Closing The Gap PBS Co-payment Program:
This is the link to privacy information:
https://www.servicesaustralia.gov.au/individuals/privacy