Greenslopes Family Practice

Please show reception staff your Medicare care and any concession cards you may have. (This Includes Pension, Health Care & Veteran Affairs Cards).

Title: Mr Mrs Ms Miss Master Dr Sir

Ime **[First Name]** _____ **Known as:** _____

Prezime **[Surname]** _____

Datum Rodjenja **[Date of Birth]** ____/____/_____ Pol **[Gender]** Muski **[Male]** Zenski **[Female]**

Adresa [**Address**] _____

_____

Kucni Telefon **[Home Phone]** _____ Telefon na poslu **[Work Phone]** _____

Mobilni [**Mobile Phone]** _____ **E-mail** _____

Zanimanje **[Occupation]** _____

Jezik koji govorite **[Main language spoken?]** _____

Medicare Card No _____ **No. on Card** _____ **Exp Date** _____

Concession Card No _____ **Exp Date**: ____/____/_____

Health Care Card Pensioner Vet Affairs

(kontakt osoba za hitne slucajeve) **Next of kin: Name** _____**Contact Number**:_____

(Veza) **Relationship:** _____

Emergency Contact:

Ime u slucaju **[Name]** _____ I kontakt telefon **[Contact number]** _____

Hitnoce **[Relationship]**_____ Isto kao kontakt osoba za hitne slucajeve _____

Bracno Stanje **[Marital status]** Neozenjen/neudata **[Single]** Ozenjen/udata **[Married]**

Razveden-a **[Divorced**] Razdvojen-a **Separated** **De facto** Udovac/Odovica **[Widowed]**

Kako ste culi za grinslops kliniku? Zaokruzite **[How did you find out about Greenslopes Family Practice? Please circle]**

Prijatelj/familija **[Friend/Family]** Apoteka **[Pharmacy]** Listic u posti **[Flyer in Mailbox]**

Pacijent iz Medoubruka **[Following Dr Talic from Meadowbrook]** Internet→ gdje **[Online → [Where]** _____

Razno (molimo specificirajte) **[Other (please specify)]** _____

I declare the above true and correct.

Signature _____ Date _____

Patient Consent

Greenslopes Family Practice values your privacy. All information about you, held at this practice, is kept in the strictest confidence. With the introduction of the Privacy Amendment (Private Sector) Act 2000 in December 2001 we are now requesting your express consent for the use and disclosure of your personal health information. We require your consent to collect personal information about you. Access to this information may be required directly or indirectly by other health care providers such as pathology services, pharmacists, specialists, hospitals and medicare. Your personal health information will not be sold by this practice to marketing companies and cannot be used for the purposes of promoting non-health related products or services. Please read this consent form carefully, tick the applicable boxes and sign where indicated below.

This Medical Practice collects such information for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history to allow us to properly assess, diagnose, treat and advise on all your health care needs. Please place a tick in the following boxes if you give consent for this information to be used by the Practice in the following ways:

❑ I give my permission for my personal health information to be used for administrative and clinical purposes to assist in the running of ***Greenslopes Family Practice***, including disclosure to others involved in my healthcare, such as treating doctors and specialists within and outside this Medical Practice. This may occur through referral to other Doctors, or for medical tests and in the reports or results returned to my doctor following referrals.

❑ I give my consent to the presence of a third party to be present during my consultation. This may include a Practice Nurse or medical student.

❑ I give my consent to be part of the Practice's National, State and Territory recall and reminder systems.

❑ I give my consent for Greenslopes Family Practice staff members to use all provided telephone numbers to contact myself and my listed Emergency Contact and Next of Kin. I understand that this might mean disclosing my personal information to either my Next of Kin for Emergency Contact.

❑ I give my consent to receiving SMS reminders of my appointments from Greenslopes Family Practice.

❑ I have been advised of the **estimated costs** in respect of the proposed medical services. I accept responsibility for payment of this account, including vaccinations and dressings if applicable.

❑ I will update my contact details including address and phone number with Greenslopes Family Practice as they change.

I understand by ticking the relevant boxes above that the Practice is authorised on my behalf to use my relevant personal health information and I am free to withdraw my consent at any one time by verbal or written notification.

Print name of Patient: …… Signature of Patient: ……

Date : ……

Print name and signature of Parent /Guardian (if under 18):

……

To be completed if patient does not speak English

I, _____ translated the above information to _____ and they have signed above.

_____ understands the Practice is authorised on their behalf to use their relevant personal information and they are free to withdraw their consent at any one time by verbal or written notification.