greenslopes family practice

Title: ☐Mr ☐Mrs ☐Ms ☐Miss ☐Master ☐Dr ☐Sir ☐Other

First Name: _____ Preferred Name: _____

Surname: _____ Date of Birth: ____/____/_____

Gender**:** ☐Male ☐Female ☐Gender Diverse ☐Non-Binary ☐Transgender ☐Other

Birth Sex: ☐Male ☐Female ☐Other

Pronouns: ☐She/Her/ Hers ☐He/Him/His ☐They/Them/ Theirs

If child *- full name of* ***parent***: _____ *Parent Date of Birth***:** ____/____/_____

Position Number of ***parent*** on Medicare Card: ☐

Address: _____ Suburb: _____

Postcode: _____ Email: _____

Home Phone: _____ Work Phone: _____

Mobile Phone: _____

Occupation: _____

Medicare Card No: ☐☐☐☐☐☐☐☐☐☐ Position number on Card: ☐ Expiry Date: ____/_____

Concession Card No: _____ Expiry Date: ____/____/_____

Type of Concession Card: ☐Health Care Card ☐Pension ☐DVA

Next of Kin

Full Name: _____ Contact Number: _____

Relationship to you: _____

Emergency Contact ☐Same as Next of Kin

Full Name: _____ Contact Number: _____

Relationship to you: _____

Marital status: ☐Single ☐Married ☐Divorced ☐De facto ☐Separated ☐Widowed

Do you wish to identify with any particular ethnic group: _____

Do you identify as: ☐Aboriginal ☐Torres Strait Islander ☐Both

How did you find out about Greenslopes Family Practice? ☐Internet ☐Family/Friend ☐Live locally/street signage ☐Referral ☐Other_____

I declare the above true and correct.

Signature_____ Date _____ **PLEASE TURN OVER**

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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 such as a practice nurse or medical student. I understand that my consent will be checked again on the day prior to my consultation if there may be a third-party present during my consultation.

❑ 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 my Next of Kin or Emergency Contact.

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

❑ I give my consent to receiving SMS clinical recalls & reminders from Greenslopes Family Practice.

❑ I accept responsibility for payment of this account, including vaccinations, dressings & other consumables 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 authorized 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: ……

If under 18 - Print name and signature of Parent /Guardian:……

To be completed if patient **does not speak English** I, _____ translated the above information to ____ _____ and they have signed above. _____ understands the Practice is authorized 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.