

Personal Information / Consent Form

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| **PERSONAL DETAILS** |  |
| Title | (TITLE) | Family Name | (SURNAME) | Given Name | (FIRST NAME) |
| Middle Name | (MIDDLE NAME) | Preferred Name | (PREFERRED NAME) | Gender (please specify) |  |
| Date of Birth | (DAY)*(Day)* | (MONTH)*(Month)* | (YEAR)*(Year)* | Occupation | (OCCUPATION) |
| Marital Status | (STATUS) | Religion | (RELIGION) | Country of birth / Ethnicity | (CofB) | Indigenous status | [ ]  *Aboriginal*[ ]  *Torres Strait Islander*[ ]  Both Aboriginal and Torres Strait Islander[ ]  Neither (non-Indigenous) |

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| **CONTACT DETAILS** |  |
| Home Address |
| (NO) | (STREET NAME) |
| *(Unit/street No) (Street Name)* |
| (SUBURB) | (POST CODE) |
| *(Suburb) (Post code)* |
| Phone (Home) | Mobile | Work phone | *Preferred contact via:*  |
| (HOME PHONE) | (MOBILE PHONE) | (WORK PHONE) | [ ]  *Mobile* [ ]  *Work phone* [ ]  *SMS* [ ]  *Email* [ ]  *Letter**Consent to SMS reminders:* [ ]  *Yes* [ ]  *No* |
| Email address | (EMAIL ADDRESS) |

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| **MEDICARE / OTHER DETAILS** |  |
| Medicare Number | (MEDICARE NO) | Reference (Number next to name) | (REF) | Expiry | (EXP) |
| Private Health Fund | (PRIVATE HEALTH) | Number | (REF) |
| [ ]  *Health Care Card* [ ]  *Pensioner Concession Card* [ ]  *Commonwealth Seniors Card* [ ]  *DVA* |
| Card Number | (CARD NUMBER) | Expiry | (EXP) |

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| **OTHER CONTACTS** |  |
| Next of Kin Name | (NEXT OF KIN) | Relationship to you | (R’SHIP) |
| Phone (Home) | (HOME PHONE) | Work | (WORK PHONE) | Mobile | (MOBILE PHONE) |
| Emergency Contact Name (if different to above) |  | Relationship to you |  |
| Phone (Home)I have read the above information and the Belgravia Medical Centre’s Privacy Policy, and I understand the reasons why my information must be collected. 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 health care given to me. I consent to the handling of my information by this practice for the purpose set out in the Privacy Policy subject to any limitations on access or disclosure that I notify this practice of. I have been offered a copy of Belgravia Medical Centre’s Privacy Policy. **Signed** **Name** **Date** | (HOME PHONE) | Work | (WORK PHONE) | Mobile | (MOBILE PHONE) |