

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) |