Blackheath Family Medical Centre

Welcome to Blackheath Family Medical Centre. To ensure we have your current details, would you please complete the following questions and return this form to Reception with your Medicare card and any valid concession cards you may have.

Your Details

Mr, Mrs, Ms, Miss (circle) Given name: ______________________ Surname: ______________________

Address: ______________________________ Suburb: ___________________ State: ______ Post Code: _______

Telephone: Home _____________ Work _____________ Mob________________ Email ____________________

Date of Birth: ___ / ___ / ___ Occupation: ____

Do you identify with any cultural group? ❑ Yes ❑ No Please specify: ____________________

Do you identify as an Aboriginal or Torres Strait Islander? ❑ Yes ❑ No

Medicare Card Number: ________________________ Ref: ___ Expiry Date: ___ / ___ / ___

Concession Card: Pensioner / Health Care Card / Seniors Card / None (circle)

Concession card number: _____________________________ Expiry Date: ___ / ___ / ___

Private health insurance fund: _________________________ Member No. ________________

Level of private health insurance cover: _________________________

Insurance company if Workers' Compensation: ______________________ Claim No: ____________________

Emergency Contact / Next of Kin

Name: ____________________________ Phone: ____________________ Relationship: _____________________

Your health

Current conditions: (Please tick) ❑ diabetes ❑ asthma ❑ chronic heart disease ❑ cancer

❑ Other conditions: (please specify)____

Current medications: ____

Past medical history: Please list any past conditions or operations you have had, including approximate year.

____

Allergies (describe reaction): ____

Describe any significant medical history within your family: ____

____

balance! Health Care

<u>Your health continued …</u>

Do you smoke? ❑ Yes ❑ No If yes, how many per day ____ Year stopped if ex-smoker: ____

Do you drink alcohol? ❑ Yes ❑ No If yes, how many units per day ____

<u>Privacy</u>

To enable ongoing care and total quality improvement within this practice, and in keeping with the Privacy Act and National Privacy Principles, we wish to provide you with sufficient information on how your personal health information may be used or disclosed and record your consent or restrictions to this consent.

Your personal health information will only be used for the purposes for which it was collected, or as otherwise permitted by law and we respect your right to determine how your personal health information is used or disclosed.

By signing below, you (as a patient/guardian) are consenting, that on obtaining your personal health information it may be used or disclosed by the practice for the following purposes:

- For use when seeking treatment by other health professionals in this practice.
- Follow up reminder/recall notices by letter or telephone (including contact via SMS to your mobile phone number) for treatment and preventive healthcare.
- For accounting procedures and the collection of professional fees.
- The diagnosis and treatment of any health condition, including the communication of information to practice staff, specialists and other healthcare providers to ensure quality care is provided.
- For legal related disclosure as required by a court of law.
- For the purposes of research only where de-identified information is used.
- General practice accreditation and quality assurance activities.
- To allow medical students and authorised staff to participate in medical training/teaching.
- For disease notification as required by law.

At all times, we are required to ensure your details are treated with the utmost confidentiality. Your records are very important and we will take all steps necessary to ensure they remain confidential.

I, __________________________ give my permission for my personal health information to be collected, used and disclosed as described above. I understand only my relevant personal health information will be provided to allow the above actions to be undertaken and I am free to withdraw, alter or restrict my consent at any time by notifying this practice in writing.

Signature: ______________________________ Date:___ / ___ / ___