

# Springwood Medical Centre



Welcome to Springwood 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: \_\_\_\_\_

\_\_\_\_\_

## Your health continued ...

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 \_\_\_\_

## Privacy

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: \_\_\_\_ / \_\_\_\_ / \_\_\_\_