Mansfield MEDICAL CLINIC

Patient Details

If you need assistance to complete this form or require an interpreter, please let our Receptionist know.

Title: .... Family Name: .... Given Name: ....

Preferred Name: .... D.O.B: __ __ / __ __ / __ __ __ __

Gender Identity: ❐ Female ❐ Male ❐ Other .... *(Please specify)*

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

Ethnicity: ❐ Australian Non Indigenous ❐ Aboriginal ❐ Torres Strait Islander
❐ Aboriginal & Torres Strait Islander ❐ Other .... *(Please specify)*

Residential Address: ....
....

Postal Address: *(If different to above)* ....
....

Home Phone: .... Mobile .... Work:...

Email: ....

Medicare No: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ Position: ___ Expiry: __ __ / __ __ / __ __
(Number to the left of your name)

Pension No: CRN ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ Expiry: __ __ / __ __ / __ __

Health Care Card No: CRN ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ Expiry: __ __ / __ __ / __ __

DVA No: --- ❐ Gold ❐ White ❐ Orange

Religion: --- *(Optional)*

Payer of Account: ❐ Self ❐ Head of Family *(Please specify below if applicable)*

Name: ----------------------------------- Phone: ---

Next of Kin: --- Phone: ---

Nature of Relationship: ---

Emergency Contact: -- Phone: ---

This practice does not bulk bill

Please note, as a result of the increased cost and complexity in providing medical care in a rural environment, a fee is charged for all visits with payment expected at the time of consultation. A copy of our fees is available at reception or on our website. We do not accept payment by American Express.

Please complete both sides

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Electronic Messages *(Please tick as applicable)*

This patient consents to receive the following electronic reminders/messages:

❒ Appointments
❒ Clinical Reminders
❒ Clinical Communication (Results & Clinical messages)
❒ Health Awareness (Leaflets & Database Research)

Health Information Collection

As a patient of Mansfield Medical Clinic we require you to provide us with your personal details and a full medical history, so that we may properly assess, diagnose, treat and be proactive in your health care needs.

We aim to protect the privacy and secure storage of your health information. You can request a copy of our privacy policy, which includes information about the collection, use and disclosure of your health information.

We require your consent to collect personal information about you and to use the information you provide in the following ways:

- Administrative purposes in running our medical practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your healthcare including treating doctors and specialists outside this medical practice.
- This may occur though referral to other doctors, or for medical tests and in the reports or results returned to us following referrals.
- Disclosure to other doctors in the practice, locums etc. attached to the practice for the purpose of patient care and teaching.
- For research and quality assurance activities to improve individual and community health care and practice management.
- Usually information that does not identify you is used but should information that will identify you be required you will be informed and given the opportunity to 'opt out' of any involvement.
- To comply with any legislative or regulatory requirements e.g. notifiable diseases.
- For reminder and/or recall notices which may be sent to you regarding your health care and management.

Please read this consent form carefully, and sign where indicated below. You can decline to have your health information used in all or some of the ways outlined above but it may influence our ability to manage your health care to provide the best outcome for you.

Consent *(Please tick as applicable and sign below)*

❒ I have read the information above and understand the reasons why my information must be collected.

❒ I understand that I am not obliged to provide any information requested of me, but failure to do so may compromise the quality of health care and treatment given to me.

❒ I am aware of my rights to access the information collected about me, except in some circumstances where access may be legitimately withheld. I will be given an explanation in these circumstances.

❒ I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.

I consent to the collection, use and disclosure of my information by the practice (including contact via SMS to my mobile phone number) for the purposes set out above, subject to any limitations on access or disclosure of which I notify this practice.

Patient's Name: .... D.O.B: __ __ / __ __ / __ __ __ __

Patient's Signature: .... DATE: __ __ / __ __ / __ __ __ __

Signed as Guardian for Child: .... Name *(Printed)*: ....

OFFICE USE ONLY	INITIALS & DATE
Entered in Best Practice	
Scanned	