Patient Information Sheet & Privacy Statement

Title: _______ Surname: ________________________________ First Name: _______________________________

Middle Name: ______________________ Preferred Name: ___________________ D.O.B: ________________

□ Male □ Female □ Other Occupation: _______________________________

If Child - full name of Parent: ____ D.O.B: ________________

Country of Birth: __________________________________

Do you identify as Aboriginal and/or Torres Strait Islander origin?

□ No

□ Yes: Please indicate which one: □ Aboriginal □ Torres Strait Islander □ Aboriginal & Torres Strait Islander

Address: ____ Suburb: __________________________

Postcode: ____________ Mobile Number ______________________Telephone Home: _______________________

Telephone Work: ______________________ E Mail: ____

Medicare Number: ______________________________Position on Card: _________ Expiry Date: _______________

Pension / HCC / DVA Card Number: _______________________________________ Expiry Date: _______________

Private Health Insurance: _______________________ Membership Number: _______________________________

Do you consent to SMS reminders? □ Yes □ No

Next Of Kin:

Surname: _____________________________________ First Name: ____________________________________

Relationship to you: _____________________________ Next of Kin Phone Number: _______________________

Emergency Contact: ☐ Same as Next of Kin

Surname: _____________________________________ First Name: ______________________________________

Relationship to you: ___________________________ Emergency Contact Phone Number: ___________________

Known Allergies: ____

Collection Statement & Patient Privacy

I hereby give express permission to Baywest Medical Centre's staff and Doctors to receive and supply Personal Medical information from or to other Medical Practitioners/Specialists/Pathology/Radiology etc on my behalf. This information is collected in accordance with the National Privacy Principles and is used to manage your health care. Your records are the property of Baywest Medical Centre and will not be released without your consent.

I acknowledge that I am wholly responsible to arrange any further appointments to discuss my test results conducted by your Doctors on my behalf at all times. If you do not understand this information please ask one of our receptionists to explain this to you.

Signed by and on behalf of the above listed patient: _______________________________Date: _________________

How did you find out about us? ☐ Word of Mouth ☐ Google ☐ Online Booking ☐ Street Signage ☐ Yellow Pages

☐ Other (Please specify)