

Patient Information Form & Privacy Statement

We are committed to providing our patients with the best care.
To do this it is essential that your health record is correct and kept up to date.

Please complete all fields of this form



**Edmondson Park
Medical**

PERSONAL DETAILS

Patient File No # _____

Title	Dr ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Mast ☐ Other ☐		
First Name		Middle Name	
Surname		Preferred Name	
Date of Birth		Gender: Male ☐ Female ☐ Transgender ☐	
		Gender At Birth: Male ☐ Female ☐	
Country of Birth:		Ethnicity:	
Do you identify as Aboriginal and/or Torres Strait Islander? Aboriginal ☐ Torres Strait Islander ☐ No ☐			
If Aboriginal or Torres Strait Islander, Are you Registered for Closing The Gap (CTG) Program? Yes ☐ No ☐			
If not please ask your GP to provide you a form to register			
Languages Spoken Other Than English:			

OTHER DETAILS:

Medicare No.		(IRN) Ref # on card		Expiry	
D.V.A No.		Gold ☐ White ☐		Expiry	
Centrelink Pension/ Health Card No.		Pension ☐ Health Care ☐		Full Expiry Date	
Seniors Card	Card #				
Residential Address					
Suburb		State		Postcode	
Phone Numbers	Mobile: Home:				
Any Known Allergies					
Allergy Reaction:					
Email Address					
Occupation					
Next of Kin Name:	Mr ☐ Mrs ☐ Ms ☐	DOB: _____			
	First Name:	Last Name:			
Next of Kin Phone:		Patient Relationship with Next of Kin:			
Address:					
Emergency Contact Name:	Mr ☐ Mrs ☐ Ms ☐	DOB: _____			
	First Name:	Last Name:			
Emergency Contact Phone Number:		Patient Relationship with Emergency Contact:			
Address:					

PARENT OR GUARDIAN DETAILS (Please complete this section if child is under 16 years of age)

First Name		Middle Name	
Surname		Mobile Number	
Date of Birth		Relationship to Child	
Medicare #		(IRN) Ref # on card	Expiry

LIFESTYLE HISTORY

Alcohol	Drinker ☐ Non-Drinker ☐	How often do you drink per week: _____ How many drinks per week: _____
Smoking	Smoker ☐ Vaper ☐ Non-Smoker ☐	No. of Cigarettes you smoke per day: _____

PLEASE TURN OVER TO COMPLETE OTHER SIDE

PRIVACY STATEMENT: Collection of Patients Information and Its Use
(Please read the following information, tick off each statement and sign below)

As a patient of our medical practice, we require you to provide us with your personal details and other relevant information so that it can be registered in our system, assessed, and properly treated for your health needs.

Your Medical Record is a Confidential Document. It is the policy of our Practice to always maintain security of personal and health information and to ensure that this information is only available to authorized members of staff. This information is collected in accordance with the National Privacy Principles and is used to manage your health care. If you wish to view a copy of our Privacy Policy, please ask one of our team members.

We require your consent to collect personal information about you and to use the information you provide in the different ways: for example (a) For the use of administrative / operational purposes of our medical practice. (b) For Billing purposes, including compliance with Medicare and Health Insurance Commission requirements (c) Disclosure to others involved in your healthcare including treating doctors, other doctors, locum medical practitioners, registrars, trainees working within our group. Your information, also with other specialists and Allied health practitioners within or outside this medical practice. (d) To comply with any legislative or regulatory requirements e.g., notifiable diseases or for court summons. (e) For reminders (letters, SMS, and emails) which may be sent to you regarding your health and management. (f) to participate in research and quality improvement programs.

If you are not clear about any information or need further information – please talk to your doctors or Practice Manager.

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 consent to the handling of my information by the practice for the purpose set out above, subject to any limitations on access or disclosure of which I notify this practice.	☐
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 consent to the handling of my information by the practice for the purpose set out above, subjected to any limitations on access or disclosure of which I notify in writing to the practice.	☐
I consent to being contacted by SMS/ phone call / letter related to my Health Issues (you will receive SMS recalls related to your health)	☐
<i><u>I have read and understand the information provided above.</u></i>	☐

--PLEASE TICK ALL OF ABOVE ONCE READ--

Please present paperwork to reception with Medicare Card and Photo ID

Signature	Patient / Guardian Signature
Patient ID	No Patient ID required for under-age children, Guardian ID must be sighted by staff
Guardian ID	Guardian ID Must be Sighted for under-age children.
Date	
<i>This section to be completed by staff</i>	
Checked By: Staff Name Signature.....Date.....	

****PATIENTS - PLEASE RETURN COMPLETED FORM TO RECEPTION
WITH PHOTO ID, MEDICARE CARD & ANY CENTRELINK CARDS****



Edmondson Park Medical

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EDMONDSON PARK, NSW, 2174

Ph: (02) 9188 8770 Fax: (02) 9188 8771
Email: info@edmondsonparkmedical.com.au

ADMIN USE ONLY

Date Sent: _____

Time Sent: _____

☐ Faxed

FAX: _____

☐ Emailed

EMAIL: _____

Request for Medical Records Transfer

Date: _____

Previous Clinic Name: _____

GP/Specialist Name: _____

Ph: _____ Fax: _____

Email: _____

Patient full name (print)	Address	DOB	COPY OF ID & MEDICARE ATTACHED
			YES/NO
Other family members (if under 18 years of age)	Address	DOB	
The above mentioned now attends this practice. To assist in their future medical management. Would you kindly forward:			
• Please do not send original documents • Their clinical records • An accurate health summary, with relevant correspondence and results • Details of any CDM or PIP Items claimed within the last 2 years. (eg GPMP, GPMHP)			
These records can be forwarded by:			
• Mail • Fax / Email			

Yours Sincerely,
Good Health Medical Central Admin Team

Patient Signature: _____

Parent Signature: _____

(parent signature required if patient is under 16 years)

- ☐ I understand only a Health Summary will be transferred, if a **Full Record** is required, I will need to organize payment with my previous Medical Practice for this file.