FLORENCE STREET Accredited General Practice

familypractice

ABN: 89 728 820 411
Suite 6, Ground Floor,
32 Florence St., Hornsby, 2077
Ph: 9476 2255 Fax: 9476 3355

We are committed to providing our patients with the best care, to do this it is essential that your medical records are up to date and accurate.

Could you please assist us by completing the following page? Date:_____

Patient Details

Title: _____ Given Names: _____Surname: _____

Date of Birth: ____/____/_____ ☐ Male ☐ Female

Home Address: _____ Suburb/Post Code: _____

Postal Address: _____ Suburb/ Post Code: _____

Phone: (H) _____ (W) _____ (M) _____

Email: _____ ☐ **Consent to SMS reminders / recalls** ☐ **Consent to emails**

Marital Status: ☐ Single ☐ Married ☐ Defacto ☐ Separated ☐ Divorced ☐ Widowed

Occupation: _____ As Australia is a genuinely multicultural society, and to tailor appropriate care, encourage understanding and appreciation between people from different nationalities and cultures please fill in:

Country of Birth: _____ Citizenship_____

Year arrived in Australia_____ Preferred Language _____ Translator Required ☐ Y ☐ N

Are you… ☐ Aboriginal ☐ Torres Strait Islander

Billing Details: ☐ **Photo I.D Sighted by Staff**

Medicare Number: _____/____ Reference Number _____ Expiry date:___/_____

Do you have a… ☐ Pension Card ☐ Health Care Card ☐ Veteran Affairs Card

Card Number: _____ Expiry Date: ____/___/_____Private Health Insurance: ☐ Y ☐ N

Emergency Contact (next of kin/parent/guardian)

Name: _____ Relationship to patient: _____

Phone: (H) _____ (W) _____ (M) _____

Next of Kin (if different from Emergency contact)

Name: _____ Relationship to patient: _____

Phone: (H) _____ (W) _____ (M) _____

How did you hear about the surgery?

☐ Transferred from Ethel St Practice ☐ Relatives Attend ☐ Word of Mouth ☐ Referred
☐ Walked Past/Saw Sign ☐ Internet ☐ Yellow Pages/White Pages
☐ Other, please specify_____

Florence St Family Practice Health Information Collection, Use and Disclosure Consent Form (Please read this consent form carefully prior to signing.)

This general practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose and treat illnesses and medical conditions, ensuring we are proactive in your health care. Your personal 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 information is used or disclosed. The information we collect may be collected by a number of different methods examples include: medical test results, notes from consultations, Medicare details, data collected from observations and conversations with you, and details obtained from other health care providers (e.g. specialist correspondence).

To enable ongoing care, and in keeping with the *Privacy Act 1988* and *Australian Privacy Principles*, we need to record your consent or restrictions to this consent. By signing below, you (as a patient/parent/guardian) are consenting to the collection, use and disclosure of your personal information for the following purposes:

- Administrative purposes in the operation of our general practice.
- Billing purposes, including compliance with Medicare requirements.
- Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice.
- Accreditation and quality assurance activities to improve individual and community health care and practice management.
- For legal related disclosure as required by a court of law.
- For the purposes of research only where de-identified information is used.
- To allow medical students and staff to participate in medical training/teaching using only de-identified information.
- To comply with any legislative or regulatory requirements, e.g. notifiable diseases.
- For use when seeking treatment by other doctors in this practice
- We may also need correspond with you via SMS or your unencrypted email about your care. For example: in order to send you follow-up reminder/recall notices for treatment and preventative healthcare or to send you a referral or e-script.. If you need more information about this please ask reception for a copy of our "Patient e-mail Policy"

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.
Please complete the form below if you understand and agree to the following statements in relation to our use, collection, privacy and disclosure of your patient information.

I, _____ have read the information above and understand the reasons why my information must be collected, and the purposes for which my information may be used or disclosed. I understand that if my information is to be used for any purpose other than that set out above, my further consent will be obtained.

I, _____ give permission for my personal information to be collected, used and disclosed as described above, **including contact via SMS to my mobile phone number or email**. I understand only my relevant personal 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.

Patient name: (please print) _____

Signature: _____ Date: _____

If not patient signing - your name (please print) _____

Your relationship to patient (e.g. Mother, Father, guardian) _____