**PATIENT INFORMATION AND CONSENT FORM**

**1. PATIENT DETAILS**

Title………. Surname……………………………. First Name(s)………..……………………

Preferred Name…………………………D.O.B………………….. Gender: Male/ Female (circle)

Are you Aboriginal or Torres Strait Islander? Yes / No Ethnicity………………………………….

(Country of Birth)

Address………………………………………………………………………………………………….

Suburb………………………… Postcode………………. Occupation……………………………..

Home Phone……………………… Mobile…………………… Work Phone………………………

Do you agree to SMS reminders? Yes / No

What is your preferred method of contact?................................................................................

Email Address…………………………………………………………………………………………

Medicare No Ref Expiry Date

/

|  |  |  |  |
| --- | --- | --- | --- |
| Please list other family members (under 16 only) you would like to or who attend The Ridge | | | |
| Name | Date of Birth | Medicare No | Medicare Ref |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Health Care Card / Pension Number………………………….. Expiry Date……………………...

Veteran Affairs Card Number………………………………….. Expiry Date………………………

**2. NEXT OF KIN DETAILS**

Title………… Surname………………………….. First Name(s)………………………………..

Address …………………………………………Suburb…………….............Postcode………..

Relationship…………………………..

Phone……………………………. Mobile…………………………………………………………

**3. EMERGENCY CONTACT - If different to Next of Kin**

Title………… Surname………………………….. First Name(s)………………………………..

Address …………………………………………Suburb…………….............Postcode………..

Relationship…………………………..

Phone……………………………. Mobile…………………………………………………………….

**PLEASE TURN OVER**

**4. ACCIDENT AND INJURY DETAILS**

Is this visit for: Worker's Compensation? YES / NO Motor Vehicle Injury or Accident? YES / NO

**Please be advised that until a claim number has been received you will be privately charged for all Worker's Compensation or Motor Vehicle visits and will be required to pay on the day of the visit and claim the visits back from your employer or the appropriate insurance department.**

**5. MEDICAL HISTORY**

**Please advise the doctor of any allergies, current medication, family medical history and cigarette and alcohol intake.**

**6. CONSENT**

I understand that the Ridge Baldivis Medical Centre complies with the Privacy Act (1988) and as part of their Privacy Policy they are committed to protecting the privacy of individuals and their personal information. The purpose for collecting my personal information is to provide quality medical and health related services and associated account keeping.

I understand that I have the right to request access to my information except where access would be denied and that the Ridge Baldivis Medical Centre makes every effort to manage my information in accordance with the National Privacy Principles and keep my records accurate and up to date. I understand that I may withdraw my consent for the Ridge Baldivis Medical Centre to use and disclose my personal information (except when legal obligations must be met).

My signature below indicates that I have read the above and consent to: (cross out what is not relevant)

The Ridge Baldivis Medical Centre collecting, using, storing and disposing of my personal information and releasing relevant information to other health professionals **to** allow quality medical care (e.g. specialist, pathologist). The release of relevant personal information to my employer, their authorised representatives and their insurer in the case or a work related consultation or service.

Inclusion in a recall register to be advised of follow up visits, medical updates and health information

I understand that all accounts must be paid at the time of the consultation and that I will be responsible for payment of any children under the age of 16 years.

Name………………………….Signature…………………………………Date…………..