

All information provided is private and confidential and is for use in your clinical file only. It is a requirement that all files contain this information for accreditation purposes. Please provide as much detail as possible to assist us in providing quality care.

TITLE: MISS ☐ MASTER ☐ MS ☐ MRS ☐ MR ☐ DR ☐ OTHER ☐

GIVEN NAME: _____ MIDDLE NAME: _____ SURNAME: _____

PREFERRED NAME: _____ DATE OF BIRTH: ____/____/____ GENDER: M ☐ F ☐ OTHER ☐

ADDRESS: _____ POSTCODE: _____

HOME NO. _____ MOBILE NO. _____ WORK NO: _____

EMAIL ADDRESS: _____ MARITAL STATUS: _____

NEXT OF KIN: _____ RELATIONSHIP: _____ PH: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PH: _____

ETHNICITY: Australian ☐ Aboriginal ☐ TSI ☐ ATSI ☐ Other _____

COUNTRY OF BIRTH: _____ LANGUAGES SPOKEN: _____

MEDICARE NO. _____ REF NO. _____ (next to name) EXPIRY DATE: _____

DVA CARD NO. _____ ☐ DVA Gold ☐ DVA White (Please tick applicable)

PENSION / HEALTHCARE CARD No. _____ EXPIRY DATE: _____

CURRENT MEDICATIONS:

MEDICAL HISTORY:

HOW DID YOU HEAR ABOUT RONDEL FAMILY PRACTICE? _____

Health Information Collection & Use Consent Form

As a patient of Rondel Family Practice we require you to provide us with your personal details and a full medical history, so that we may assess, diagnose, treat and be active 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, Allied Health Professionals and specialists outside this medical practice. This may occur through 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 and Allied Health Professionals 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 letters, which may be sent to you regarding your health care and management. 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. I have read the information above and understand the reasons why my information must be collected.
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- 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 understand that depending on the age of my child (16 and over) and given my child’s right to privacy, in the clinical judgement of the doctor treating my child I may be prevented from access to information regarding my child’s healthcare.
- 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.

PATIENT’S NAME: _____

PATIENT’S SIGNATURE: _____

DATE: _____

SIGNED AS GUARDIAN FOR CHILD: _____

NAME: _____