Dr Christopher Weekes

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PATIENT INFORMATION FORM

Confidential Information

SURNAME:_____ **GIVEN NAME:**_____

TITLE: ☐MISS ☐MRS ☐MS ☐DR ☐Prof. ☐MR MIDDLE NAME:_____

DOB: _____

PREFERRED NAME:_____ PRONOUNS:_____

RESIDENTIAL ADDRESS: _____

SUBURB:_____ STATE:_____ POSTCODE: _____

POSTAL ADDRESS (If different from above) _____

MOB: _____ HOME: (_____) _____ ALT: _____

EMAIL: _____

MEDICARE No.: _____ REF : _____ EXP DATE: _____

DVA No.: ☐ YES ☐ NO _____

PRIVATE HEALTH FUND ☐ YES ☐ NO

NAME OF FUND: _____ MEMBERSHIP No.: _____

NEXT OF KIN / EMERGENCY CONTACT INFORMATION

NAME: _____ RELATIONSHIP: _____

MOB: _____ HOME:_____

GENERAL PRACTITIONER

GP NAME: _____ PRACTICE LOCATION: _____

Privacy Statement

The Federal *Privacy Act 1988* requires your written consent to collect personal information about you. Please read this information carefully and sign as indicated below.

We may need to collect information from previous doctors, health care workers, pathology, or x-ray services that you have consulted with, for the primary purpose of providing quality health care. This means that we will use the information you provide in the following ways:

- Best assess your health care needs and provide medical treatment.
- Administration purposes, including contacting you by telephone, email, or SMS.
- Billing purposes and debt collection, including compliance with Medicare, DVA and Private Health Funds.
- Disclosure to others involved in your care, including allied health professionals, treating doctors, specialists and hospital booking staff outside this practice. This may occur through referral to other doctors, surgery at hospitals, for medical tests and in the reports or results returned to us following the referrals.

By signing the below, I have read the above information and voluntarily give my consent, it is understood that your information will be accessed by non-medical and medical staff of this practice as indicated above and is used within the parameters outlined in the *Privacy Act 1988*:

☐ I give permission to obtain medical information relating to my condition from other healthcare providers (e.g., my GP, specialists, pathology, allied health, and radiology providers).

☐ I give permission for this practice to communicate with me by text message or email, including sending documents which may contain personal or medical information. I understand that the security of information sent via email cannot be guaranteed.

Name: _____

Signature: _____ Date: _____