PATIENT DETAILS FORM

Kangaroo Island MEDICAL Clinic

PLEASE NOTE: This is *not* a bulk billing practice – FULL PAYMENT IS REQUIRED. Payment can be made by cash, EFTPOS or credit card. *If payment is a concern, please discuss this with the GP at the time of your consultation.*

PATIENT NAME: (Mr/Mrs/Miss/Ms) _____ **DATE OF BIRTH:** ____ / ____ / ____

Medicare No: _____ (Patient Reference # ____) Expiry Date: ____ / ____ **MALE/FEMALE**

Veteran's Affairs: _____ Expiry Date:____/____ (Gold or White) card

(*If White card, please provide proof of entitlements*)

Pension/Health Care (please circle): _____ Expiry Date: ____ / ____ / ____

Home Address: _____ Post Code: _____

Postal Address: _____ Post Code: _____

Phone: (____) _____ Email: _____

Mobile: _____ ☐ *Please tick if you DO NOT wish to receive SMS reminders*

***IF PATIENT UNDER 16 years of age**: Parent's name:* _____ *Date of Birth:* ____ / ____ / ____

Parent's Medicare number (if different to child) *Medicare No.* _____ (Patient Ref # ____)

EMERGENCY CONTACT PERSON: _____ Phone: _____ Mobile: _____

Cultural Background:

Is the patient of Aboriginal or Torres Strait Islander origin?

No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, both Aboriginal and Torres Strait Islander ☐

Other cultural background ☐ Please specify: _____

CONSENT TO COLLECTION AND USE OF YOUR PERSONAL INFORMATION. Please read and sign:

This practice provides high quality continuing care for you. In compliance with the Privacy Legislation and consistent with maintaining confidentiality and trust with your doctor the practice wishes to inform you that all information collected about you requires your consent. The information we collect is used for:

- Diagnosis and treatment of your problem including communicating with practice staff, specialists and other health care providers involved in your care
- Health Care prevention – including recall and reminder systems (which may be sent by SMS)
- Accreditation and Quality Assurance
- Billing and collection of professional fees
- For work-related or medical-legal reasons
- Teaching and research

Medical care requires full knowledge of patient health information by all members of a medical team. To ensure quality and continuity of patient care a patient's information is shared with other health care providers from time to time. We may also disclose information about you to outside contractors to carry out activities on our behalf, such as an IT service provider, solicitor or debt collection agent.

I provide consent for the doctors of Kangaroo Island Medical Clinic to collect, use and disclose my information for the quality and continuity of my health care, and for any other necessary reason in accordance with its Practice Privacy Policy. (A full copy of the Practice Privacy Policy is available from our reception staff).

I understand that I may withdraw my consent as to the use and disclosure of my personal information in writing (except when legal obligations must be met).

I further understand that Kangaroo Island Medical Clinic is a private practice and that a fee will be incurred each time I visit the doctor. I acknowledge that I am responsible for payment of this fee on the day of consultation.

NAME:..... Signed..... Date .....