**Personal details**

Mr/Mrs/Ms/Miss/Master: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\*Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Sex: Male/Female

Gender Identity: Male/Female/Non-Binary/Gender Diverse/Transgender

Preferred Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Current Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Medicare Card No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Reference No: \_\_\_\_\_ Expiry Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Health Care Card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiry Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Pension Card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiry Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Veterans Affairs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiry Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Country of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Ethnicity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Aboriginal/TSI: Yes/No If Yes, registered for CTG? Yes/No

Is English your first language? yes/no

\*Do you require an interpreter? yes/no If yes please specify language\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Next of Kin**

Mr/Mrs/Ms/Miss: \_\_\_\_\_\_\_First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Phone No : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency contact (different from Next of Kin)\***

Mr/Mrs/Ms/Miss: \_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Phone No : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\* This information must be provided**

 **Please Turn Over**

**Beckenham Medical Centre**

**Privacy Policy**

**Collection**

This means we will only collect information about you that is critical to providing you with optimal care. Information includes full medical history, ethnicity, contact details, Medicare and Centrelink details, genetic information and billing and account details. This information will be collected directly from patients, as well as from other sources such as previous GP’s and Specialists, other Health Care Providers and Hospitals. Both our Practice Staff and Doctors may participate in the collection of this information and have access to the information in order to carry out their duties. All Practice Staff are aware that a breach of patient confidentiality is considered a dismissible offence. Currently medical records are kept indefinitely. You can ask to read our complete privacy policy should you want further information.

**Use and Disclosure**

With the patient’s consent, the Practice Staff will use and disclose the patient’s information for purposes such as account keeping and billing purposes, referral to other Medical Practitioner, Health Provider, Hospitals, sending specimens, management purposes, quality assurance, Workers Compensation claims, where legally required to do so for insurance and court records, and Australian Childhood Immunisation Register.

**Attendance**

If you cannot attend or no longer need an appointment, please contact us **at least two hours** in advance so that we can give your appointment to other patients in need.

As a Practice, we understand that there are sometimes circumstances that make it impossible to attend an appointment. However, if there are 2 DNA (Did not attend) appointments, we do have a policy to charge a fee. This fee is to cover the administration and time cost that the practice has to accrue due to unattended appointments.

**Access**

Patients are entitled to access their own health records at any time convenient to both themselves and the Practice. Access can be denied where to provide access would create a threat to life, legal impediment, the access would impact on the privacy of another, request is frivolous or information relates to legal proceedings or is in the interest of national safety. We ask that the patient request be in writing to the Doctor concerned.

**PATIENT SMS CONSENT FORM**

Patient’s Name .....................................................................................

Date of Birth …../……/………

The purpose of this form is to inform you and seek your consent to the use and disclosure of your personal information (including health information) in regards to our reminders and notifications systems within our practice.

At Beckenham Medical Centre, we have implemented technology solutions to enable communications with our patients via SMS.

I acknowledge that the Beckenham Medical Centre will use contact details provided by me (as updated by me from time to time) to communicate with me. To the extent that the mobile number I have provided to this general practice is utilised by more than one patient, I understand and consent that all SMS and phone communications will be directed to that number.

Please complete and sign below if you understand and agree to the acknowledgements and consent set out above.

Parent/Guardian Name (if patient is under 18yrs) ..........................................................

Signature .............................................

Date ....................................................

In addition to other communications, we may send you from time to time, we will regularly send you the following types of communications:

**1. appointment reminders** – notifications to you to remind you of upcoming appointment dates with the practice as well as allowing you to confirm your appointment;

**2. clinical reminders** - notifications to you to remind you to contact the practice to arrange appointments for regular clinical check-ups, medical procedures, immunisations, care plans etc;

 **3. clinical communications** - communications to you about your clinical care at the practice such as returned pathology results or clinical messages from the medical practitioner; and

**4. health awareness** – communications to you in relation to general health care information and health care services provided by this general practice including notification about changes to our clinic opening hours, and information about health care services provided by this general practice.

* I understand I may withdraw my consent to use and disclose my personal information (except where legal obligations must be met, and take full responsibility for the consequences.

I acknowledge and agree that, in the course of providing health care services to me, Beckenham Medical Centre may need to use and disclose my personal information (including any health information) as set out in this form.

**Patient Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Dated:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_