Erskineville Doctors

Patient Details

Your NAME should be as written on your Medicare Card

TITLE	*FIRST NAME*	*SURNAME*	*DATE of BIRTH*	*SEX*
				M F

Preferred name______________________________________

ADDRESS
Street_______________________ Home______________________________ Suburb____________________Postcode________ Work ________________________________ Email_____________________________ Mobile________________________________ What is your preferred contact number? Please circle: Home Work Mobile I consent to contact via sms reminders ☐

MEDICARE NUMBER

										LINE NO		EXPIRY DATE	

PENSION/CONCESSION HEALTH CARD No. __________________________ Expiry Date _____________

VETERANS CARD No___________________________Expiry Date _____________RECORD no._____

PEOPLE TO CONTACT IN CASE OF EMERGENCY
1. Name________________________ Relationship_____________________ Contact phone no. __________________ Is this person a patient here?_______ Please tick if you wish to record this person as your Next of Kin ☐
NEXT OF KIN (If different to above) 2. Name___________________________ Relationship______________________ Contact phone no._________________ Is this person a patient here?_________

ETHNIC/CULTURAL BACKGROUND		Where did you hear about Erskineville Doctors?
☐ ABORIGINAL ☐ TORRES STRAIT ISLANDER ☐ OTHER________________________-		☐ Live in the area ☐ from a friend ☐ From another doctor ☐ Other ____________________________

For children please state which parent or carer is the recipient of rebates from Medicare ______________________________
(Nominated Head of family for billing purposes)

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Patient consent for use of personal health information

a) Within the practice

I, ______________________________ ___________________ give permission for my medical records and personal health information to be shared between doctors of this practice. I understand that all doctors and staff of this practice are covered by confidentiality agreements. I also understand that should I not want any part of my medical or personal information disclosed to other doctors or staff of this practice, I need to inform my usual doctor of this issue.

b) Outside the practice

I agree to allow my doctor to communicate relevant medical details to specialist doctors, hospital medical staff, pathology labs, and other health care providers, eg. physiotherapist, podiatrists, etc, involved in my medical care.

This practice may from time to time participate in medical research projects with outside organisations. We stress that all information shared is depersonalised (ie. Names of patients are NOT given). If you expressly DO NOT want any of your clinical information used in this manner, please indicates with a cross in the following box □

The practice will from time to time send our reminders for various health checks. If you DO NOT wish to receive these reminders please tick the following box □

c) For dependants

As guardian/parent of _________________________________ I authorise their health information to be used in the above mentioned manner.

Your signature
Patient/Parent/Guardian____**Date**___________
_

Name of Witness ____ **Signature of witness**______________________