This information is private and confidential and is for use in your clinical file only.

Patient Details (please print in block capitals and mark in the boxes):

Title:	Surname:		First Name:	
Middle Name(s):			Preferred Name:	
Email address:			Date of birth (DD/MM/YYYY):	Australian citizen: ☐ Yes ☐ No
Street Address:			Suburb:	Postcode:
Mobile phone:	Home phone:		Business phone:	Contact at work: ☐ Yes ☐ No
Sex at birth: ☐ M ☐ F ☐ Other	Gender identity: ☐ M ☐ F ☐ NB ☐ T ☐ Other			Pronouns: ☐ M ☐ F ☐ Other

Personal Information (please provide info and mark boxes as required):

Please describe your ethnicity or ethnic identity, such as English, Irish, Italian, South African:	
	☐ Aboriginal ☐ Torres Strait Islander

Please fill your healthcare cover details and indicate the type of cover you have:			
☐ Medicare ☐ No Medicare	Medicare Card number:	Ref number:	Expiry date (DD/MM/YYYY):
☐ Veterans' Affairs ☐ Pension	Concession Card number:	Colour/Type:	Expiry date (DD/MM/YYYY):

Contact Preferences (please mark boxes as required):

Please indicate consent for all methods of contact you wish to receive and mark your first preference:									
SMS	☐ Consent ☐ Preference	Mobile	☐ Consent ☐ Preference	Email	☐ Consent ☐ Preference	Home	☐ Consent ☐ Preference	Work	☐ Consent ☐ Preference

Next of Kin (please provide info and mark boxes as required):

Full Name:	Relationship:
Street Address:	☐ Same as above

Emergency Contact (please provide info and mark boxes as required):

Full Name:		Relationship: ☐ Same as next of kin
Mobile phone:	Home phone:	Business phone:

PRIVACY CONSENT FORM

I give permission for the Doctors at Bicton Medical Clinic to collect, use and disclose my personal information as outlined. I understand that I am able to withdraw my consent as to the use and disclosure of my personal information except when legal obligations must be met. I am aware that I am entitled to access my own health records as outlined in the Practice Privacy policy except where access would be denied as per the Privacy Act 1988 guidelines.

Patient Consent to Collect and Disclose Information

The Privacy Act 1988 requires Medical Practitioners to obtain consent from you, the patient, to collect, use and disclose your personal information. This information is needed to properly treat and advise you and may be collected by the Medical Practitioner or our practice staff.

Normally we would collect the information directly from you but there may be occasions when we will need to obtain the information from others, such as:

1. Other general Medical Practitioners and Specialists.
2. Other health professionals such as physiotherapists, psychologists, psychiatrists, pharmacists, nurses, dentists, etc.
3. Hospital and Day Surgery facilities.

In an emergency we may need to obtain personal information from relatives or other sources if we are unable to obtain your express prior consent.

Information collected, used and disclosed may include full medical history, family medical history, genetic and ethnicity details.

Use and Disclosure

The Practice will only use your personal and health information for the following reasons:

1. Referral to a Medical Specialist or another health care provider.
2. Provision of a prescription in digital form to a pharmacy to which you have taken a prescription.
3. Referral to a hospital for treatment and advice.
4. Advice on treatment options.
5. To prevent or lessen a serious threat to an individual's life, health or safety.
6. Where legally required to do so, such as providing records to a court, mandatory reporting of child abuse or the notification of diagnosis of certain communicable diseases.
7. Account keeping and billing purposes.
8. To meet our obligations of notification to our insurers and medical defence organisation.

Access to your Records

You are entitled to access your own health records at any time convenient to both you and the Practice.

Consent to be included in the Practice reminder system

In order to provide continuity of care, and in the interests of preventative medical management the Practice maintains a reminder system. Your consent is needed to be a participant in the recall system, and you have the right to refuse if you wish.

SIGNATURE ____________________ DATE________

PRINT NAME ______________________________________

PLEASE TAKE THIS SECTION TO YOUR DOCTOR

Patient Details (please print in block capitals):

Title:	Surname:	First Name:	
Middle Name(s):		Date of birth (DD/MM/YYYY):	Blood type if known:

Medical History (please list or mark "nil" if none):

Current medication(s) and dosage:

Known allergies:

Dates of operations or previous illnesses (FEMALE PATIENTS: Please include the date and result of your last Pap Smear):

Social History (please provide info or mark a box):

How many days do you drink alcohol per week?	How many standard drinks would you usually consume?
☐ I do not drink alcohol. ☐ I no longer drink alcohol but have in the past (year stopped: ______)	

How many cigarettes do you smoke per day?	When did you start smoking?
☐ I do not smoke. ☐ I no longer smoke but have in the past (year stopped: ______)	

Family History (please provide info and mark boxes as required):

	Are they alive?		Significant History or Illness			
Mother	☐ Unknown ☐ Alive	Age at death: ____________	☐ Diabetes ☐ Colon	☐ Hypertension ☐ Depression	☐ Heart ☐ Breast	☐ Stroke ☐ Kidney
Father	☐ Unknown ☐ Alive	Age at death: ____________	☐ Diabetes ☐ Colon	☐ Hypertension ☐ Depression	☐ Heart ☐ Cancer	☐ Stroke ☐ Kidney
Other family details:						

At Bicton Medical Clinic we strive to provide high quality care, appropriate to meet our client's health care requirements. How did you originally find out about our surgery?

☐ Word of Mouth ☐ Referral (from whom?): ☐ Health Engine ☐ Drive/walk past ☐ Google

- Friends
- Relatives

____