

**Patient Information**

We need this information to provide the best quality care. This form complies with the RACGP standards for general practices

(5th edition). This means your personal health information is kept private and secure, as required by federal and state privacy

laws. If you have concerns, please leave blank and discuss with your GP.

Please notify us promptly of any changes in your contact details. Accurate contact details help us identify you and your

medical records, and allow us to contact you promptly about tests and results.

 **Dr Andrew Osborne Dr Raymond Wen Dr Dr Amanda Wright Dr Claire Veith Dr Anna Carter**

 **Dr Kerryn Gijsbers Dr Radhika Sheorey D Dr Amanda Burnside Dr Tien Nguyen Dr Laura Beaton**

**Practice Name:**

**East Brunswick Medical Centre**

Section A: **Personal details**

**Title Surname Given Names**

**Date of birth (dd/mm/yyyy) Gender Marital status**

 **Single Married Defacto Separated Divorced Widowed**

**Medicare card numbers Medicare reference number Medicare expiry date**

**Pension, Health Care Card, or Veterans Affairs number** (if applicable**) Type of Veterans Affairs card Expiry date**

**Occupation**

**Home Address**

**Postal Address**

**Telephone number Work number Mobile Number**

**Email**

**Next of Kin**

**Name Relationship to you**

**Telephone number Work number Mobile Number**

Who can we contact in an emergency?

**Name Relationship to you**

**Telephone number Work number Mobile Number**

**Do you have an advance care directive for end of life care? Yes No For more information talk to your GP.**

**How did you hear about EBMC?** **Word of Mouth Internet Referred by existing patients Walking Past Phone Book**

Section B: **Cultural background**

**Knowing your cultural background can help us provide healthcare that meets your individual needs.**

**Are you Aboriginal or Torres Strait Islander origin?**

**No Yes, Aboriginal Yes, Torres Strait Islander Yes, Both Aboriginal and Torres Strait Islander**

**Other cultural background (e.g.: Mediterranean, Asian, African) Country of birth**

**Is English your first language? If not, do you require an interpreter? Please specify language**

Yes No Yes No

Section D: **Consent**

Our practice uses a reminder system to help you maintain your health. **I consent to being contacted with**

The practice sends reminders by post, email, telephone or SMS **reminders to help me maintain my**

For procedures such as vaccinations, cervical screening and other health **health by post, email, telephone or Yes No**

reviews. **SMS**

Our practice also sends information to the Australian **I consent to being contacted with**

Immunisation Register and Cervical Screening Register. **reminders to help me maintain my**

These registers also send reminders, which can be helpful if you move. **health from these organisations Yes No**

Our practice can upload information that you request and grant permission **I consent to information being**

for to your My Health Record following discussion + consent from you **uploaded to My Health Record**

 **following discussion with me Yes No**

Information collected by your doctor will be used to provide you with quality patient care. Your personal health information will be kept confidential and will not be disclosed, unless required by law, to any third part without your consent wither verbally or in writing. I consent to the collection of medical information for the purpose of providing me with quality patient care. I am aware of my right to access information collected about me, except in some circumstances where access might be legitimately be withheld. I understand I will be given explanation in these circumstances.

**Signature of patient or guardian**  **Date:**

Section E: **Transfer of health information**

You may have consistently consulted with a GP at another practice. The health information held by that GP may assist us with your future healthcare needs. You may wish to have a copy or summary of your health records transferred to this practice. Please ask the reception team for information about how this can take place.

**Previous GP Details**

**Doctors Name / Practice Name**

**Address**

**Phone Fax**

**Please advise us if your contact information or Medicare details change.**

**Office Use Only**

**Completed by**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pt File Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_