PACIFIC PINES MEDICAL CENTRE

PATIENT INFORMATION SHEET

To help our Reception staff with your details please provide the following information

Would you like to be a permanent patient at our Practice? Yes □ No □

Title: _________ Surname: _____________________________First Name: __________________________ D.O.B:________________

If Child - full name of Parent: ____ D.O.B: __________________________

Do you identify as Aboriginal and/or Torres Strait Islander origin?

No □ Yes □ Aboriginal Yes □ Torres Strait Islander Yes □ Aboriginal Torres Strait Islander

Address: ____ Suburb: _______________________________

Postcode: _________________ Telephone Home: __________________________ Work: ____________________________________

Mobile: ____ E Mail ____

Medicare Number: ____Expiry Date: ___________ Reference No: _________________

Pension/HCC Card Number: __________________________________ Expiry Date: ____________

Known Allergies: ____

Do you Smoke: Yes □ No □ Ex-Smoker □ **Do you drink Alcohol: Yes □ No □ If yes how many per day:** ___________

Country of Birth: _______________________________________Religion: ____

What is your preferred language? _________________________Cultural background: ____________________________________

Next Of Kin

Surname: ____________________ First Name: _______________Relationship to you: _______________Phone:_________________

Emergency Contact

Surname: ____________________First Name: _______________Relationship to you: _______________Phone:__________________

Contact

How would you like to be contacted by our Practice? (please tick your preference)

□ **Mobile** □ **Work Number** □ **Home Number** □ **SMS** □ **Email** Consent to SMS Reminders: **Yes** □ **No** □

Collection Statement & Patient Privacy

I hereby give express permission to Pacific Pines Medical Centre's staff and Doctors to receive and supply Personal Medical information from or to other Medical Practitioners/Specialists/Pathology/Radiology etc on my behalf.
Your records are the property of Pacific Pines Medical Centre and will not be released without your consent.
Pacific Pines Medical Centre send all our prescriptions electronically and may view the dispensing history of any of your prescriptions.
I acknowledge that I am wholly responsible to arrange any further appointments to discuss my test results conducted by your Doctors on my behalf at all times. If you do not understand this information, please ask one of our receptionists to explain this to you.

Signed by and on behalf of the above listed patient: ___________________________________

My Health Record

I give permission for this practice to upload information to **My Health Record.**

HIC ONLINE

Authorisation to Lodge Patient Claims

Do you authorise this location/practice to lodge your claims electronically with Medicare and for Medicare to pass the following enrolment and benefit information to this location for verification?

* The patient's current Medicare card number
* The patient's first name and reference number
* The patient's postcode, and
* Where applicable, display the benefit amount for each service

My Health Record & HIC Online Permission - Signed: ____