Boroondara Health & Wellness Centre
738 Glenferrie Rd., Hawthorn Victoria 3122
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Health Information Collection and Use Consent Form

As a patient of our medical practice we require you to provide us with your personal details and a full medical history, so that we may properly assess, diagnose, treat and be proactive in your health care needs.

We aim to protect the privacy and secure storage of your health information. You can request a copy of our privacy policy, which includes information about the collection, use and disclosure of your health information.

We require your consent to collect personal information about you and to use the information you provide in the following ways. Please read this consent form carefully, and sign where indicated below.

- Administrative purposes in running our medical practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your healthcare including treating doctors, specialists and allied health professionals outside of this medical practice. This may occur though referral to other doctors, or for medical tests and in the reports or results returned to us following referrals.
- Disclosure to other doctors in the practice, locums etc. attached to the practice for the purpose of patient care and teaching.
- For research and quality assurance activities to improve individual and community health care and practice management. Usually information that does not identify you is used but should information that will identify you be required you will be informed and given the opportunity to “opt out” of any involvement.
- To comply with any legislative or regulatory requirements e.g. notifiable diseases.
- For reminder letters which may be sent to you regarding your health care and management.

You can decline to have your health information used in all or some of the ways outlined above but it may influence our ability to manage your health care to provide the best outcome for you.

I have read the information above and understand the reasons why my information must be collected.	☐
I understand that I am not obliged to provide any information requested of me, but failure to do so may compromise the quality of health care and treatment given to me.	☐
I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.	☐
I consent to the handling of my information by the practice for the purpose set out above, subject to any limitations on access or disclosure of which I notify this practice.	☐
I consent to receiving occasional medical updates via sms or email such as flu vaccine arrivals and health warnings.	☐
I consent to receiving reminders, recalls and results where appropriate via sms	☐

OR

I am unsure and would like to discuss this further with someone from the medical practice before I sign.	☐

Patient’s Full Name : ……..... **Date :** …….....

Patient’s Signature: …….....

If the patient is under 16 years of age, or unable to sign for themselves

Guardian’s Full Name: ……

Guardian’s Signature: …… **Relationship to Patient:** …….

NEW PATIENT INFORMATION

Date: ____/____/_____

TITLE (Circle): Mr Mrs Ms Miss Dr Other (Please Specify): _____ GENDER: M F Other _____

GIVEN NAME (on Medicare Card): _____ SURNAME: _____

KNOWN AS (Nickname / Preferred Name): _____ DATE OF BIRTH: ____/____/_____

MEDICARE NUMBER: _____ REF NUMBER: ____ (Number next to patient's name on the card)

MEDICARE EXPIRY DATE: ____/_____ Do you have Private Health Insurance? Name: _____

Pension/HealthCare/DVA (G W O)Card No. (If applicable): _____ Expiry Date: ____/____/_____

ADDRESS (In Australia ONLY): _____

_____ POSTCODE: _____

HOME PHONE: _____ WORK PHONE: _____

MOBILE: _____ E-MAIL: _____

OCCUPATION: _____ ETHNIC BACKGROUND: _____

PREFERRED LANGUAGE (If other than English): _____

- Were you born in Australia? YES ☐ NO ☐
- Are you of Aboriginal origin? YES ☐ NO ☐
- Torres Strait Islander origin? YES ☐ NO ☐

PERSON TO CONTACT IN AN EMERGENCY (In Australia ONLY)

TITLE (Circle): Mr Mrs Ms Miss Dr Other (Please Specify): _____

FULL NAME:_____ PHONE NUMBER: _____

RELATIONSHIP TO PATIENT: _____

DETAILS OF PERSON RESPONSIBLE FOR PAYING ACCOUNTS (If the Patient is NOT the Payer)

TITLE (Circle): Mr Mrs Ms Miss Dr Other (Please Specify): _____

GIVEN NAME (on Medicare Card): _____ SURNAME: _____

KNOWN AS (Nickname/Preferred Name): _____ DATE OF BIRTH: ____/____/_____

MEDICARE NUMBER: _____ REF NUMBER: ____ (Number next to payer's name on the card)

MEDICARE EXPIRY DATE: ____/_____

ADDRESS (In Australia ONLY): _____

_____ POSTCODE: _____

HOME PHONE: _____ WORK PHONE: _____

MOBILE PHONE: _____ RELATIONSHIP TO PATIENT: _____

NEW PATIENT HEALTH SUMMARY

Date: ____/____/_____

Please remove this page and give it to the Doctor during your consultation

Please Read and Answer questions carefully and tick YES or NO where appropriate

FULL NAME: _____ DATE OF BIRTH:: ____/____/_____

OCCUPATION: _____

Do you have any Allergies/Reactions to Medications, Food, or Anything Else? YES ☐ NO ☐

If **YES**, please List Allergies: _____

_____

Describe the Reaction: _____

_____

Do you have any **Family History** of: Heart Disease ☐ Diabetes ☐ Cancer ☐ Other ☐

(If **Other**, Please Specify): _____

If you ticked **ANY** of the above conditions, which Family Member/s: _____

Do you have any **Past** or **Ongoing** Medical Conditions? YES ☐ NO ☐

If **YES**, please list: _____

_____

_____

Do you take any **Prescribed** or '**Over the Counter**' Medications? YES ☐ NO ☐

If **YES**, please list: _____

_____

_____

- Are you a Smoker? YES ☐ NO ☐ If **YES**, how many per day: _____
- Are you an Ex-Smoker? YES ☐ NO ☐ If **YES**, what year did you quit: _____
- How many days a week do you drink Alcohol?: _____
- On a day of drinking, how many Standard Drinks would you consume?: _____
- How many Caffeinated Drinks do you drink per day? (Tea, Coffee, Coke, Red Bull, etc.): _____