Personal Information / Consent Form

Belgravia Medical Centre

PERSONAL DETAILS

Title		Family Name		Given Name			
Middle Name				Preferred Name		Gender (please specify)	
Date of Birth	*(Day)* *(Month)* *(Year)*			Occupation			
Marital Status		Religion		Country of birth / Ethnicity		Indigenous status	☐ *Aboriginal* ☐ *Torres Strait Islander* ☐ Both Aboriginal and Torres Strait Islander ☐ Neither (non-Indigenous)

CONTACT DETAILS

Home Address

(Unit/street No) *(Street Name)*

(Suburb) *(Post code)*

Phone (Home)	Mobile	Work phone	*Preferred contact via:*
			☐ *Mobile* ☐ *Work phone* ☐ *SMS* ☐ *Email* ☐ *Letter* *Consent to SMS reminders:* ☐ *Yes* ☐ *No*
Email address			

MEDICARE / OTHER DETAILS

Medicare Number		Reference (Number next to name)		Expiry	
Concession Card Number				Expiry	
☐ *Health Care Card*	☐ *Pensioner Concession Card*	☐ *Commonwealth Seniors Card*		☐ *DVA*	
Private Health Fund				Number	

OTHER CONTACTS

Next of Kin Name				Relationship to you	
Phone (Home)		Work		Mobile	
Emergency Contact Name (if different to above)				Relationship to you	
Phone (Home)		Work		Mobile	

I have read the above information and the Belgravia Medical Centre's Privacy Policy, and I understand the reasons why my information must be collected. I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of health care given to me. I consent to the handling of my information by this practice for the purpose set out in the Privacy Policy subject to any limitations on access or disclosure that I notify this practice of. I have been offered a copy of Belgravia Medical Centre's Privacy Policy.

Signed **Name** **Date**