# Personal Information / Consent Form

Belgravia Medical Centre

## PERSONAL DETAILS

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Title | | Family Name | | Given Name | | | |
| Middle Name | | | | Preferred Name | | ☐ *Male* ☐ *Female* | |
| Date of Birth | *(Day)* *(Month)* *(Year)* | | | Occupation | | | |
| Marital Status | | Religion | | Country of birth / Ethnicity | | Aboriginal Torres Islander origin? | ☐ *Yes* ☐ *No* |

## 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 | | Expiry | |
| Private Health Fund | | | | Number | |
| ☐ *Health Care Card* | ☐ *Pensioner Concession Card* | ☐ *Commonwealth Seniors Card* | | ☐ *DVA* | |
| Card Number | | | | Expiry | |

## OTHER CONTACTS

| | | | | | |
|---|---|---|---|---|---|
| Next of Kin | | | | Relationship to you | |
| Phone (Home) | | Work | | Mobile | |
| Emergency Contact | | | | 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**