

# CONFIDENTIAL PATIENT INFORMATION

## Welcome to St Peters Family Practice

Our doctors and staff aspire to provide you with the best possible quality care in a professional, friendly and comfortable environment.

The details requested below will assist us to accurately prepare your medical records and should be read with the accompanying **Privacy Act – Patient Consent Information**.

<b>Title (Please circle)</b>	<b>MR.</b>	<b>MRS.</b>	<b>MS.</b>	<b>MISS</b>	<b>MASTER</b>
<b>Surname</b>					
<b>First Name</b>					
<b>Date of Birth:</b>					
<b>Street Address</b>					
<b>Suburb and Post Code</b>					
<b>Occupation</b> (Include place of employment)					
<b>Home Phone</b>					
<b>Work Phone</b>					
<b>Mobile Phone</b>					
<b>Email</b>					
<b>Medicare Number</b> (Include Reference Number)				<b>Expiry Date</b>	
<b>DVA (Please circle)</b>	<b>GOLD CARD</b>	<b>WHITE CARD</b>	<b>Expiry Date</b>		
<b>Pension Number</b>				<b>Expiry Date</b>	
<b>Health Care Card Number</b>				<b>Expiry Date</b>	
<b>Private Health Cover</b> (Member Number & Cover)					
<b>Next of Kin</b> (Name and Phone Number)					
<b>Emergency Contact</b> (Name & Phone number )					

### Reminder Systems:

We believe a proactive, preventive approach to the maintenance of our patient's general health and well being is an important part of General Practice. Our Patient Recall System provides our patients with preventive care and early case detection reminders, e.g. immunisations, annual health checks, skin checks and pap smears.

**Do you wish to have any relevant health reminders sent to you?**

Yes  No

**If we need to contact you what is your preferred method of contact:**

Phone  Mail  Email

**As a part of this system and in the event we need to contact you for reasons like a change of appointment time or test results, we may need to leave a discreet message on your answering service/voice mail. Do you give your consent for us to do this?**

Yes  No

### Privacy Act Consent:

I have read the information about the Privacy Act. I understand how the practice may collect and use my personal information and my signature indicates my consent

**Signed** \_\_\_\_\_ **Dated** \_\_\_\_\_

## Your Cultural Background:

Australia is a genuinely multicultural society. To tailor appropriate care for people from different nationalities and backgrounds:-

Do you identify as from a culturally diverse and/or non- English speaking background?

If Yes, are you of or from?

- Aboriginal or Torres Strait Islander origin
- China
- Greece
- India
- Iraq
- Italy
- Korea
- Malaysia
- New Zealand
- Philippines
- Sri Lanka
- Sudan
- Thailand
- United Kingdom
- Vietnam
- Other cultural or ethnic background (please indicate)\_\_\_\_\_

## Payment of Accounts:

We request payment at the time of consultation. If you are not responsible for payment of your account, or you are making a WorkCover or Third Party Claim, please fill in the following details:

Name of Organisation: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Claim Reference Details: \_\_\_\_\_

## Referral:

Please indicate how you were referred to the practice:

[ ] Friend/family member [ ] Another doctor or specialist [ ] Employer [ ] Yellow Pages

## What you will receive:

After completing this form you will receive a **Patient Information Leaflet** outlining all the relevant information you will require on the Practice. This includes consulting sessions for each of our doctors and details on the services we provide.

Please take one of our 3 monthly newsletters from the reception desk for the latest practice news. Would you like us to email you a copy of our newsletter when it is published? Please be assured your privacy is protected – this practice does not allow spamming or unsolicited emails.

Yes  No



**ST PETERS FAMILY PRACTICE  
ACCREDITED MEDICAL PRACTICE**