

Office 2, 263 Pennant Hills Rd, Thornleigh 2120 Ph: (02) 8287 3400

**CONFIDENTIAL PATIENT FILE INFORMATION**

SURNAME: Mr / Mrs / Ms \_\_\_\_\_

FIRST NAME: Miss / Mast / Dr \_\_\_\_\_

PARENTS' NAME (if patient is a child): \_\_\_\_\_

ADDRESS: \_\_\_\_\_

BIRTH SEX: MALE / FEMALE GENDER IDENTITY: MALE / FEMALE / OTHER

HOME TELEPHONE NUMBER: \_\_\_\_\_ WORK TELEPHONE NUMBER: \_\_\_\_\_

MOBILE PHONE NUMBER: \_\_\_\_\_ EMAIL: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ DRIVER'S LICENCE No: \_\_\_\_\_

MEDICARE NUMBER: \_\_\_\_\_ No. on card: \_\_\_\_\_ Expiry: \_\_\_\_\_

DVA / PENSION / HCC card no. if applicable: \_\_\_\_\_ Expiry: \_\_\_\_\_

HEALTH FUND if applicable: \_\_\_\_\_ HEALTH FUND NO: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ EMPLOYER NAME: \_\_\_\_\_

NEXT OF KIN / EMERGENCY CONTACT NAME: \_\_\_\_\_ Relationship: \_\_\_\_\_

NEXT OF KIN / EMERGENCY CONTACT NUMBER: \_\_\_\_\_

Are you of Aboriginal or Torres Strait Islander cultural background? YES / NO

Have you received two doses of a COVID vaccine? YES / NO / ONLY ONE DOSE

Country of Origin: \_\_\_\_\_

Have you, or any member of your immediate family ever attended this practice before? YES / NO

How did you hear about us? \_\_\_\_\_

**Consent to receive SMS messages for clinical reminders/appointments: YES / NO**

**Consent to receive prescriptions electronically (E-scripts) via SMS: YES / NO**

Our practice participates in research for quality improvement purposes. All patient information remains confidential and de-identified. (De-identified means you will not be identified from the information given).

**Consent to be included in de-identified data extraction: YES / NO**

Under Privacy Legislation enacted from 21 December 2001 all patients have right access to their health records. Should you require copies of any of your records we are entitled under the same legislation to charge for administrative and/or photocopy costs involved.

I consent to my health record being reviewed as a part of the quality improvement activities at this practice.

Reminder System: We participate in the State/Territory reminder system, if you do not wish to be part of our system, please inform our reception staff.

**CANCELLATION POLICY:** Any missed or late cancellations of appointments without PRIOR notification will incur a **\$50 fee**. To avoid the fee, you must inform us at least 2 hours PRIOR to your appointment (via phone call or email).

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/20\_\_\_\_