Rooftop Medical Practice
Thornleigh

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: THERE IS A $50 FEE FOR NON-ATTENDANCE OF AN APPOINTMENT WITHOUT NOTIFICATION. CANCELLATIONS NEED TO BE MADE 2 HOURS PRIOR TO YOUR APPT. PLEASE SEE RECEPTION FOR FURTHER DETAILS

Patient Signature: _____ **Date:** ____/____/ 20___