

# Eastbound Medical Clinic

*Specialist Family Physicians*

|                                 |  |
|---------------------------------|--|
| TITLE: MR/MASTER/MISS/MRS/MS/DR | FIRST NAME   |
| MIDDLE NAME                     | SURNAME  |
| KNOWN AS                        | D.O.B    /    /    GENDER: MALE/FEMALE/TRANSGENDER |

**MEDICARE CARD NUMBER**

|   |  |  |  |  |  |  |  |  |  |           |         |     |                |     |       |  |
|---|--|--|--|--|--|--|--|--|--|-----------|---------|-----|----------------|-----|-------|--|
|   |  |  |  |  |  |  |  |  |  | REF NO    |         | EXP | /              |     |       |  |
| ABORIGINAL / TORRES STRAIT ISLANDER / BOTH / NON INDIGENOUS |  |  |  |  |  |  |  |  |  | ETHNICITY |         |     |                |     |       |  |
| PENSION/HEALTH CARE/DEPT VET AFFAIRS                        |  |  |  |  |  |  |  |  |  |           | EXP     |     |                | / / |       |  |
| PRIVATE HEALTH & AMBULANCE MEMBER: Y/N                      |  |  |  |  |  |  |  |  |  |           | o Basic |     | o Intermediate |     | o Top |  |

|  |
|--|
| ADDRESS  |
| POSTCODE   |
| POSTAL ADDRESS (tick if same as above <input type="checkbox"/> ) |
| POSTCODE   |

**CONTACT NUMBERS** \*[ALLOW SMS REMINDERS Y / N](#) - [ALLOW PRACTICE EMAILS Y / N](#)

|        |      |      |
|--------|------|------|
| MOBILE | HOME | WORK |
| EMAIL  |      |      |

**NEXT OF KIN**

|                |                                |
|----------------|--------------------------------|
| FIRST NAME     | SURNAME                        |
| RELATIONSHIP   | D.O.B    /    /                |
| CONTACT NUMBER | PERMISSION TO CONTACT    Y / N |

**EMERGENCY CONTACT DETAILS** (Contacted first in the event of an emergency)

(tick if same as above  )

|                |                                |
|----------------|--------------------------------|
| FIRST NAME     | SURNAME                        |
| RELATIONSHIP   | D.O.B    /    /                |
| CONTACT NUMBER | PERMISSION TO CONTACT    Y / N |

**PERSONAL DETAILS**

|                  |                      |
|------------------|----------------------|
| MARITAL STATUS   | OCCUPATION           |
| COUNTRY OF BIRTH | Yr of Arrival in Aus |
| SPOKEN LANGUAGE  | PREFERRED LANGUAGE:  |

*Please Turn Over*

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**Workcover account terms:** Accounts for Workcover patients will be the responsibility of the patient. Payment will be required at the time of consultation. It is the responsibility of patients to organise reimbursement of these accounts from their employer.

**Private account terms:** Full payment is required at the time of consultation. Credit terms are only available through prior arrangement

**Failure to attend policy:** a late cancellation fee will apply for failing to attend appointments. Please notify us well in advance if you need to cancel your appointment.

**I consent to the retrieval and distribution of medical information, including reports and results from medical tests, from and to others involved in my health care, including treating doctors, specialists, hospitals and other health care facilities outside this medical practice. I consent to de-identified data to be used for NHMRC government approved quality improvement and research activities.**

### Privacy and consent form

#### Our policy advises you:

That we need your consent to collect information about you

That you can request access to the information we hold about you

That you may discuss any concerns that you have about how we handle your information with your doctor or management

How you can obtain information about any possible breaches of privacy

Ask your doctor or see our reception staff if you would like more information about our privacy policy or how to access information from your health record

*\*Privacy Act 1988 (Cth) My Health Record Act 2012 (Cth) and Victorian Health Records Act 2001*

### How did you find out about us? (Please tick)

- |   |  |  |
|---|--|--|
| <input type="radio"/> Facebook              | <input type="radio"/> Friend/Relative              | <input type="radio"/> Flu vaccine sign/ banner |
| <input type="radio"/> Bayside Community Hub | <input type="radio"/> Convenience of location      | <input type="radio"/> Google Maps              |
| <input type="radio"/> Web page              | <input type="radio"/> Skin cancer sign/banner      | <input type="radio"/> Other (please state)     |
| <input type="radio"/> Health Engine         | <input type="radio"/> Cosmetics clinic sign/banner | .....  |

Translator required Y / N

|   |                     |                 |
|---|---------------------|-----------------|
| <b>SIGNATURE:</b>   | <b>NAME (PRINT)</b> | <b>DATE / /</b> |
| IF UNDER 18 YEARS OF AGE or REQUIRING CONSENT <b>PARENT/GUARDIAN SIGNATURE:</b> |                     |                 |
| <b>NAME (PRINT)</b>   | <b>DATE</b>         |                 |

Thank you for attending Eastbound Medical Clinic!

Online bookings available for registered patients: [www.eastboundclinic.com.au](http://www.eastboundclinic.com.au)



Or [www.healthengine.com.au](http://www.healthengine.com.au)



[www.facebook.com/eastboundclinic](http://www.facebook.com/eastboundclinic)