

Eastbound Medical Clinic

Specialist Family Physicians

TITLE:	FIRST NAME
MIDDLE NAME	SURNAME
KNOWN AS	D.O.B / / GENDER: MALE/FEMALE/TRANSGENDER

PLEASE CIRCLE: ABORIGINAL / TORRES STRAIT ISLANDER / BOTH / NON INDIGENOUS ETHNICITY:

*Ethnicity refers to a social group whose members share a common origin and history, and possess dimensions of collective cultural individuality (Ministry of Economic Development 2003)

MEDICARE CARD NUMBER

										REF NO (next to name)		EXP /
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PENSION/HEALTH CARE/DEPT VET AFFAIRS NUMBER:

EXP :

PRIVATE HEALTH & AMBULANCE MEMBER: Y / N

ADDRESS

POSTCODE

POSTAL ADDRESS (tick if same as above)

POSTCODE

CONTACT NUMBERS

MOBILE

Allow SMS reminders? Y / N

HOME

WORK

EMAIL

Allow practice emails? Y / N

NEXT OF KIN (someone in a close personal relationship with you who has a personal interest in your welfare)

RELATIONSHIP

D.O.B / /

FIRST NAME

SURNAME

CONTACT NUMBER

PERMISSION TO CONTACT Y / N

Tick if same as above

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

RELATIONSHIP

D.O.B / / (must be >18)

CONTACT NUMBER

PERMISSION TO CONTACT Y / N

Please turn over

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PERSONAL DETAILS

COUNTRY OF BIRTH	Yr of Arrival in Aus
MARITAL STATUS	OCCUPATION
SPOKEN LANGUAGE	PREFERRED LANGUAGE:
INTERPRETER REQUIRED? Y / N	

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*

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 POLAR and NHMRC government approved quality improvement and research activities.

SIGNATURE: _____ **NAME (PRINT)** _____ **DATE** / /

IF UNDER 18 YEARS OF AGE or REQUIRING CONSENT **PARENT/GUARDIAN SIGNATURE:**

NAME (PRINT) _____ **DATE** _____

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

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

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eastboundclinic.com.au



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 with the latest clinic news and updates
 Simply search **facebook.com/eastboundclinic**

