Mount Compass Medical Centre

Patient Information Form – Please hand form to Reception

Title: Mr/Mrs/Ms/Miss/Mast/Dr

Given Names………………………………………………………….....Surname:……………………………………………..

Sex: Male/Female Date of Birth:……………………………… Country of Birth:…………………………………

Are you of Aboriginal and or Torrens Strait Islander Origin: Yes/No

Do you identify with any other cultural group: yes/no Please specify…………………………………………

Marital Status: Single Married Defacto Widowed Divorced Separated

Occupation:……..

Medicare Number: ………………………………….Patient Ref………….Expiry……………………………………...

DVA Number…………………………………………….Veteran Affairs Expiry………………………………………..

Pension/HCC Number:………………………………………………………………Expiry:………………………………… …..

Residential Address:………

Suburb………………………………………………………………………………….Postcode………………..………………….

Postal Address (if different)……………………………………………………………………………………………………..

Suburb………………………………………………………………………………….Postcode…………………….……………

HomePhone:…………………………….Work…………………………………………..Mobile:……………..…………...

Email………………………………………………………………………………………. Ambulance Cover Yes/No

Allergies Yes/No Details..

Next of Kin Surname:…………………………………………..Given Names……………………………..………………..

Phone:…………………………………………………………………….Relationship:……………………………………………..

Emergency Contact Surname:……………………………….. Given Name:………………………………………………

Phone:………………………………………………………………………Relationship :……………………………………………………..

How did you hear about us? (circle) Advertising word of mouth live local online other

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Consultation Fees

Mount Compass Medical Surgery is a private and Bulk Billing is not routine.

- **Children under 16 will be Bulk Billed**
- **Pension & Concession Card Holders will be Bulked Billed**
- **Private Patient please be advised the FULL payment is required at the time of the consultation**
- **Fees apply for non-attended appointments or cancellations less than 2 hours prior notice**

Patient signature……………………………………………………………………………. Date …………………………………

<u>Mount Compass Medical Centre</u>

Shop 5/30 Main Rd, PO Box Mount Compass 5210, SA Ph.: 8556 8365 Fax: 8556 8096

Dr Phillip Duguid: 025673AF Dr Judith Hamel: 030310BH Dr Ahmet Lokaj: 259472BT

<u>Patient Personal Health Information Consent Form</u>

This practice is bound by the *Federal Privacy Act 1998* and National Privacy Principles, and also complies with the *South Australian Health Records Act 2001*. To enable ongoing care and total improvement within this practice, we wish to provide you with sufficient information on how your personal health information may be used or disclosed and record **your consent** or restrictions to this consent.

This information includes medical details, family information, name, address, employment and other demographic data, past medical and social history, current health issues and future medical care, Medicare number, accounts details and any health information such as a medical or personal opinion about a person's health, disability or health status.

Your personal health information will only be used for the purpose for which it is being collected, or as otherwise permitted by law and we respect your right to determine how your personal health information is used and disclosed.

By signing below, you (as a patient/guardian) are consenting, that on obtaining your personal health information it may be used or disclosed by the practice for the following purposes.

- Follow up reminder/recall notices for treatment and preventive healthcare.
- For accounting procedures and the collection of professional fees.
- The diagnosis and treatment of the heath condition, including the communication of information to, practice staff, specialists and other healthcare providers to ensure quality care is provided.
- Accreditation and Quality Assurance activities are conducted by professional trained non-treating GP's and other professionally trained persons e.g. General Practice Managers.
- For legal related disclosure as required by a court of law
- For the purpose of research only where de-identified information is used.
- For disease notification as required by law
- To allow medical students and staff to participate in medical training/teaching using only de-identified information.
- For the use when seeking treatment by other doctors in the practice.

I, ____ give my permission for the personal health Information to be collected, used and disclosed as described above. I understand that only my relevant personal health information will be provided for the above described purposes and that I can freely withdraw, alter or restrict my consent at any time by notification in writing.

Patient Name: ____

Signature: ____

If not Patient signing, name: _________________________________Relationship_________________

PRACTICE ONLY: Witnessed by: (staff signature):________________