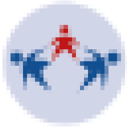

ALPAT MEDICAL SERVICES

Waverley Family Healthcare
58 Pinewood Drive, Mount Waverley, 3149 VIC

Anytime Healthcare
401 Blackburn Road, Mount Waverley, 3149 VIC

This complete medical history is important for you to obtain good health care. **Please complete both sides of this form.** If you are unsure or have any questions, please discuss with your doctor.

Personal Details

Title : Mr / Mrs / Miss / Ms________ **First Name**:________________________________

Surname : **Date of Birth**:

Medicare no.:___________________________________ **Ref** :_____ **Expiry Date** :____/____

Gender : M / F / Intersex / Transgender / Other: _________________ **Ethnicity:**_____________

Country of Birth:_______________________ Aboriginal/ Torres Strait Islander: Yes / No

Address:

Suburb: **Postcode**: **Mobile:**

Home phone number: Work:

Email:

Concession (please circle): Healthcare card, Pensioner, DVA, None

Concession card number: _ Expiry:____/____/____

Marital Status (circle): Single, Married, Engaged, Divorced, de facto, have a partner, widowed, other: _____

Emergency Contact Information

Name: ____ **Relationship**:_________________

Contact number: ___________________________________

Next of kin name: ____________________________________ Relationship:___________________

Next of kin contact number: ____________________________

Patient History

Occupation: _________________________ Any religious affiliation:________________________

Preferred language:____________________ Any special needs: __________________________

Previous Clinic Details

Previous Doctor:

Previous clinic name:

Address:

PLEASE TURN OVER

Medical History

Smoking (circle): Never, Smoker, Ex-smoker

Major illnesses/operations: ____

____

Allergies: ____

Relevant family medical history:____

____

Medications: ____

Health Information Collection and Use Consent

As a patient of our medical practice we require you to provide us with your personal details and a full medical history, so that we may properly assess, diagnose, treat and be proactive in your health needs. We aim to protect the privacy and secure storage of your health information. You can request a copy of our privacy policy, which includes information about the collection, use and disclosure of your health information.

We require your consent to collect personal information about you and to use the information you provide in the following ways.

- ❖ Administrative purposes in running our medical practice. Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- ❖ Disclosure to others involved in your healthcare including treating doctors and specialists outside this medical practice. This may occur though referral to other doctors, or for medical tests and in the reports or results returned to us following referrals.
- ❖ Disclosure to other doctors in the practice, locums etc. attached to the practice for the purpose of patient care and teaching.
- ❖ For research and quality assurance activities to improve individual and community health care and practice management. Usually, information that does not identify you is used but should information that will identify you be required, you will be informed and given the opportunity to “opt out” of any involvement.
- ❖ To comply with any legislative or regulatory requirements e.g., notifiable diseases.
- ❖ For reminder letters which may be sent to you regarding your health care and management.

You can decline to have your health information used in all or some of the ways outlined above but it may influence our ability to best manage your healthcare.

Please read the following statements and sign where indicated below

I have read the information above and understand the reasons why my information must be collected.

I understand that I am not obliged to provide any information requested of me, but failure to do so may compromise the quality of healthcare and treatment given to me

I am aware of my rights to access the information collected about me, except in some circumstances where access may be legitimately withheld. I will be given an explanation in these circumstances.

I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.

I consent to the handling of my information by the practice for the purpose detailed on this form, subject to any limitations on access or disclosure of which I notify this practice.

Name (or parent/guardian):

____

Date: ________________

Signature:

____

If you have concerns or would like to discuss this further, please let staff know