Patient Information Sheet & Privacy Statement

PLEASE PRINT CLEARLY

Would you like to be a permanent patient at our Practice? ☐ Yes ☐ No

Title: _______ Surname: ____ First Name: ____________________________________

Middle Name: _______________________ Preferred Name: ______________________ D.O.B: ____________________

☐ Male ☐ Female ☐ Non-binary ☐ Gender diverse ☐ Transgender ☐ Different Identity ________________

☐ Preferred Pronouns ________________

Country of Birth: _______________________________________ Occupation: ____

If Child - full name of Parent: ____ D.O.B: ____________________

Do you identify as Aboriginal and/or Torres Strait Islander origin?

☐ No ☐ Yes: ☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal & Torres Strait Islander

Address: ____ Suburb: ____________________________

Postcode: ____________ Mobile Number ___________________________ Telephone Home: _________________________

Telephone Work: ______________________ E Mail: ____

Medicare Number: _________________________________ Position on Card: ________ Expiry Date: ____________________

Pension / HCC / DVA Card Number: ____ Expiry Date: ____________________

Private Health Insurance: ____________________________ Membership Number: __________________________________

Do you consent to SMS reminders? ☐ Yes ☐ No

EMERGENCY CONTACT PERSON – No 1:

Surname: __________________ First Name: __________________ Relationship to you:___________ Phone: ________________

Next of Kin / Emergency Contact Person – No 2: ☐ Same as Above

Surname: __________________ First Name: __________________ Relationship to you:___________ Phone: ________________

COLLECTION STATEMENT & PATIENT PRIVACY

I hereby give express permission to Baywest Medical Centre's staff and Doctors to receive and supply Personal Medical information from or to other Medical Practitioners/Specialists/Pathology/Radiology etc on my behalf.

Your records are the property of Baywest Medical Centre and will not be released without your consent.

Baywest Medical Centre may send your prescriptions electronically and may view the dispensing history of any of your prescriptions.

I acknowledge that I am wholly responsible to arrange any further appointments to discuss my test results conducted by my Doctors on my behalf at all times. If you do not understand this information, please ask one of our receptionists to explain this to you.

Medicare : Authorisation to Lodge Patient Claims

Do you authorise this practice to lodge your claims electronically with Medicare and for Medicare to pass the following enrolment and benefit information to this practice for verification?

* The patient's current Medicare card number
* The patient's postcode, and
* The patient's first name and reference number
* Where applicable, display the benefit amount for each service

Signed by, or on behalf of the above listed patient: ___________________________________Date: __________________

How did you find out about us? ☐ Word of Mouth ☐ Google ☐ Online Booking ☐ Street Signage ☐ Facebook

☐ Other (Please specify) ________________________________