

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 _____

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

NEXT OF KIN:

Surname: _____ First Name: _____ Relationship to you: _____ Phone: _____

Emergency Contact: Same as Next of Kin

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.

Signed by, or on behalf of the above listed patient: _____ Date: _____

HIC ONLINE

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

HIC Online Permission - Signed: _____

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

Other (Please specify) _____