The Rowley Road Clinic

Title (Mr, Mrs, Ms, Mast, Miss):	
Surname:	
First Name:	
Middle Name:	
Preferred Name:	
Date of Birth:	
Age:	
Birth Gender or Identifying Gender:	
Ethnicity/ Country of Birth:	
Are you of Aboriginal or Torres Strait Islander origin?	
Address (Home):	Address (Postal):
Home Phone Number:	
Work Phone Number:	
Mobile Phone Number:	
Do you consent to TEXTING for reminders and results?	YES NO (Please circle one of the above.)
Email Address:	
Medicare Number	
Number next to name:	Expiry:

Pension Concession Card Number: Pension Concession Expiry:	
Health Care Card Number: Health Care Card Expiry:	
DVA Card Number: DVA Card Type (white/Gold): White card eligible Condition:	
Health Insurance Fund: Health Insurance Fund Number:	
Religion:	
Current Occupation:	
Marital Status:	

Next of Kin:

Name:	
Relationship to You:	
Phone Number:	
Address:	

Emergency Contact:

Name:	
Relationship to You:	
Phone Number:	
Address:	

Please list all medications taken by you, including dosage:
Please list any vitamins or complementary medications taken by you:
Do you have allergies? If yes, please list allergies and the nature and severity of your reaction:
Please list any current illness:
Please list any past illnesses, including operations:
Do you smoke cigarettes? If yes, how many do you smoke per day? How old were you when you started smoking?
Have you smoked cigarettes in the past? If yes, how many cigarettes did you smoke per day? How old were you when you stopped smoking?
Do you consume alcohol?

If yes, how many days per week/ month /year do you consume alcohol?

On the days you consume alcohol, how many standard glasses of alcohol do you consume?

Do you do any regular exercise? If yes, please provide details:

Do you have a family history of any illness including heart problems, stroke, diabetes, high blood pressure, cholesterol problems or cancer?

Please provide details including which family member, age of onset and age of death (if applicable):

Immunisations: Do you give consent for your immunisations to be imported from the Immunisation Register?

The Rowley Road Clinic

We require your consent to collect personal information about you. Please read this information carefully, and sign where indicated below.

This medical practice collects information from you for the primary purpose of providing quality health care. 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 care needs. This means we will 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 the medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals.
- Disclosure for research and quality assurance activities to improve individual and community health care and practice management. You will be informed when such activities are being conducted 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.

Cancellation Policy

- Our cancellation policy is designed to ensure fairness to both patients who are kept waiting for appointments as well as doctors who are striving to meet the demand for their services.
- If you fail to attend your first appointment or give less than two hours notice for a cancellation as a new patient, a $50 non-attendance fee will apply before you are able to re-book at the clinic again.
- If you are a regular patient and you fail to attend your appointment or give less then two hours notice before cancelling, a warning will be recorded on your file as the first missed appointment.

If you fail to attend a second appointment after this, a $50.00 non-attendance fee will apply before you are able to re-book at the clinic again.

Patient Consent

- I have read the information above and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling patient information.
- I understand that I am not obliged to provide any information requested of me, but my failure to do so might compromise the quality of the health care and treatment given to me.
- I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand 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, subject to any limitations on access or disclosure that I notify this practice of.

I consent to SMS for reminders and results being sent & will inform staff if the mobile is a 'shared' phone.

Patient Name:
Patient Signature: _____ Date:

OR (IF PATIENT 15 YEARS & UNDER)

Signed as Guardian for the child:
Name (Printed):