Colchester Medical Centre

310 Colchester Road, North Bayswater Vic 3153
Ph: 03 9720 5515 Fax: 9720 5004
ABN: 99 006 700 492

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Updated Patient Information (June 2024)

Title:_____ Surname: _____ First Name: _____

Preferred Name: _____ Gender: _____

Date of Birth: _____ / ____ / ____

Address: _____

Suburb: _____ Postcode: _____

Phone: _____ Mobile number: _____

Email address: _____

Medicare Number: _____ Ref No. _____ Exp. ____/____

Pension / Health Care Card number:_____ Exp. ____/____

DVA Card: _____ Exp: ____/____

Seniors Health Care Card: _____ Exp: ____/____

Emergency contact: _____ Phone: _____ Relationship _____

NOK (different to above):_____ Phone: _____ Relationship _____

Country of Birth: _____ Cultural Background: _____

Do you identify as Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither ☐

Do you require an interpreter service? What Language or service? _____

Please list all your allergies: _____

Do you consent to My Health Record: Yes ☐ No ☐

Do you have an Advanced Care Plan? Yes ☐ No ☐

Will you be a regular patient of our clinic and consent to registration with My Medicare

Yes ☐ No ☐

You have the right to deal with us anonymously or under a pseudonym unless it is impracticable for us to do so or unless we are required or authorised by law to only deal with identified individuals. Please speak to reception.

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Patient Consent

Both Knoxfield and Colchester medical centres collect information from you for the purpose of providing quality health care. We require you to provide us with your personal details and a medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs.

We may use the information you provide in the following ways:

- Administration purposes
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your health care, including treating doctors and specialists outside this practice i.e. through referrals, medical tests, reports or results.
- Disclosure to other doctors, medical students, allied health workers and nurses who may work within both practice settings and Accreditation surveyors, for the purpose of patient care, teaching and accreditation.
- Disclosures for research and quality assurance activates to improve individual and community health care and practice management. This information will be de-identified.
- Providing our patients with preventative care and early case detection reminders (e.g. immunisations, annual health checks, bone bus initiative, skin checks and pap smears)
- For legal purposes e.g. court orders or subpoenas as required by law.
- For infectious disease notification as required by law.
- During the course of providing medical services through My Health Record Shared Health Summaries or Event Summaries.

By signing this document below, I agree to the following:

- I have read the information above and understand the reasons why my information may be collected. I am also aware that both clinics have a privacy policy on handling sensitive patient information.
- I understand I am not obliged to provide any information requested of me, but that my failure to do so may compromise the quality of 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 may 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 purposes other than set out above, my further consent must be obtained.
- By completing and providing a signature below, I consent to the handling on my information by both Knoxfield and Colchester Medical Centres for the purposes set out above.

Patient or Guardian Name:_____

Signature: _____

Date: ____ / ____ / ____