Elanora Heights
medical practice

Welcome to Elanora Heights Medical!

TITLE	FIRST NAME	SURNAME	DATE OF BIRTH	SEX	
				M	F

Please write your NAME as written on your Medicare Card.

HOME ADDRESS

Street _____

Suburb_____

State _____ **Postcode**_____

Email _____

PHONE NUMBERS

Home _____

Work _____

Mobile _____

Occupation _____

MEDICARE NUMBER *Ref #* | *Card Number* | *Expiry Date* /

Centrelink issued (Please Circle) Pension or Concession or Healthcare Card Number _____ _____ _____ **Expiry Date** _____

Veterans Card Number _____ **Record Number** _____

WHAT IS YOUR ETHNICITY / CULTURAL BACKGROUND? AUSTRALIAN ☐ OTHER ☐ (Please indicate)

Do you identify as being: ABORIGINAL ☐ TORRES STRAIT ISLANDER ☐ BOTH ☐

PERSON TO CONTACT IN CASE OF EMERGENCY

Name_____ Relationship _____ Phone Number _____

OTHER FAMILY MEMBERS / NEXT OF KIN

FIRST NAME	LAST NAME	DOB	MEDICARE NUMBER	REF #	Expiry Date	Contact Number	EMAIL	SEX	
								M	F
								M	F
								M	F
								M	F

Where did you hear about The Elanora Heights Medical Practice?

☐ From a friend ☐ I live in the area ☐ From another professional ☐ Google ☐ Website ☐ Other (please specify)

The Elanora Heights Medical Practice Patient Consent for use of Personal Health Information:

- **Within the practice :**
  I, (your name) _____ give permission for my medical records and personal health information to be shared between doctors of this practice. I understand that all doctors and staff of this practice are covered by confidentiality agreements. I also understand that should I not want any part of my medical or personal information disclosed to other doctors or staff of this practice, I need to inform my usual doctor of this issue.
- **Outside the practice:**
  - **a)** Furthermore, I agree to allow my doctor to communicate relevant medical details to specialist doctors, hospital medical staff, pathology labs, and other health care providers e.g. physiotherapists, podiatrists, etc. involved in my medical care.
  - **b)** This practice from time to time participates in medical research projects with outside organisations. We stress that all information shared is **depersonalised** (i.e. names of patients are **NOT** given). If you expressly **DO NOT** want any of your clinical information used in this manner, please indicate with a cross in the following box ☐
  - **c)** The practice will use your mobile number to provide text message appointment reminders. If you **DO NOT** wish to receive these please tick the following box ☐
  - **d)** The practice will from time to time send out reminders for various health checks. If you **DO NOT** wish to receive these reminders please tick the following box ☐
- **Dependants – If you are a guardian/parent of** _____ I authorise that their health information be also used in the abovementioned manner.

Signature – Patient/ Parent/ Guardian _____ **Date** ___ / ___ / 2018