New Patient Consent Form

PERSONAL DETAILS

First Name: ______________________ Surname: ______________________

Middle: ______________________ Preferred Name: ______________________

Date of Birth: ______________________ Gender: Male ◯ Female ◯ Other ◯

ATSI: ◯ Aboriginal or ◯ Torres Strait Islander Ethnicity: ______________________

CONTACT DETAILS

Home phone: ______________________ Mobile phone: ______________________

Street Address: ______________________

Suburb: ______________________ State: __________ Postcode: ______________________

Email address: ______________________

Emergency Contact Details

Name: ______________________ Tel: ______________________

Relationship: ______________________

Next of Kin (if different to above)

Name: ______________________ Tel: ______________________

Address: ______________________

Relationship: ______________________

Medicare Card No. ______________________ Reference No. ______________________

Expiry: ______________________

Private Health Fund: Membership No:

Aged pension card or healthcare card:

Card type:

◯ HCC ◯ Pension

Card No.

Expiry (mm/yy)

DVA Card no: Card Colour:

Management of Patient Health Information

Geriatric Care Australia collects information for the primary purpose of providing quality healthcare. We ask for personal details and a full medical history so that we may properly assess, diagnose, and treat illnesses and be pro-active in healthcare delivery. We will also collect, hold, use, and disclose the information you provide in accordance with the Privacy Act 1988 and Australian Privacy Principles (March 2014).

CONSENT

- [ ] I consent to Geriatric Care Australia requesting copies of my medical records from other providers and hospitals.
- [ ] I consent to receiving emails and SMS appointment reminders with the contact information provided
- [ ] I have read the Geriatric Care Australia Privacy Policy and consent to the use of my information as described. View policy here: geriatriccareaustralia.com.au/privacy-policy

SIGN HERE

I consent to my personal information being collected, held, used and disclosed in accordance with the Geriatric Care Australia Privacy Policy.

Signature: Date D D M M Y Y

SIGN HERE

I give consent to the presence of a third party to be present during my consultations. This may include a Nurse, Carer, Medical Student, Family Member or a friend, Translator, Centrelink or Workcover representative.

Signature: Date D D M M Y Y