

Personal Details

Family Name		Address	
Given Names		Suburb	
Preferred Name		Postcode	
Title		Home phone	
Date of Birth		Mobile phone	
Gender		Work phone	
Email		Country of Birth	
Are you of Aboriginal or Torres Strait Islander origin? <input type="checkbox"/> Yes, Aboriginal <input type="checkbox"/> Yes, Torres Strait Islander <input type="checkbox"/> Yes, Aboriginal and Torres Strait Islander <input type="checkbox"/> No		Ethnicity	
		Language spoken at home	
		Do you require an interpreter or other communication service? <input type="checkbox"/> No <input type="checkbox"/> Yes, Please specify	

Medicare Information

Medicare Card No.		Reference No. (next to your name)		Expiry Date	
Dept Veterans Affairs Card No.		Colour		Expiry Date	
Pension No.				Expiry Date	
Health Care Card No.				Expiry Date	

Alternative contacts

Next of Kin		Mobile No.	
Relationship to you		Daytime phone	
Emergency Contact (1)		Mobile No.	
Relationship to you		Daytime phone	
Emergency Contact (2)		Mobile No.	
Relationship to you		Daytime phone	

Privacy

You may find a copy of our Privacy Policy at our website: bartonlanepractice.com.au or from the practice

I give consent for my personal health information to be used for administrative purposes to assist in the running of Barton Lane Practice and the coordination of my care, including disclosure to others involved in my healthcare such as referring doctors, treating doctors and/or specialists, allied health services and diagnostic service providers within and outside of Barton Lane Practice.

I give consent to be part of Barton Lane Practice's service updates and appointment reminders and notifications (including SMS).

I give consent to be part of recall and reminder systems for national registry purposes (e.g. cervical screening, bowel cancer screening) and for personal follow up care.

If I have a My Health Record, I give consent for health care providers at Barton Lane Practice to access this record as part of providing and coordinating my care.

I give consent for my personal health information (in a de-identified form that cannot be traced back to me as an individual) to be used in quality improvement activities to improve individual, community health care and practice management.

I consent to receiving information about research projects being conducted by and through Barton Lane Practice.

I have read and understand the above information. I understand I am free to withdraw my consent at any time by contacting Barton Lane Practice.

Signature

Name

Date

For Office Use

File updated by

Date Entered

Signature