GLASS STREET MEDICAL CLINIC
105 Glass Street, Essendon, VIC, 3040
PHONE: (03) 93792242
FAX: (03) 9351 0974

(MR. MRS. MS. MST. MISS) SURNAME: ..……..…….……
FIRST NAME: ……... DATE OF BIRTH: ……..……

PHONE NO: …… MOBILE: ……..……..……...
ADDRESS: ……..……
…….POST CODE: ……..…...
(10 digits) (next to name)
MEDICARE NO: …….. REF. NO: …….. EXPIRY: ……..…..

PENSION ❑ VETERANS' AFFAIR ❑ HEALTHCARE CARD❑
CARD NUMBER: ……..…... EXPIRY: ……..

PRIVATE HEALTH INSURANCE: YES NO (Please Circle)
BASIC HOSPITAL ❑ INTERMEDIATE ❑ TOP HOSPITAL ❑

ABORIGINAL or TORRES STRAIT ISLANDER: YES NO (Please Circle)

COUNTRY OF BIRTH: ……..... ETHNICITY: ……

OCCUPATION: ..……...

NEXT OF KIN: NAME: ……..…… SURNAME: ……..
RELATIONSHIP TO YOU: …….. PHONE NO: ……

EMERGENCY CONTACT: NAME: ……..…… SURNAME: ……..…….
RELATIONSHIP TO YOU: …….. PHONE NO: ……

REF DOCTOR: ..……
PROVIDER NO: ……...
DATE OF REF: ……..…..…PERIOD OF REFERRAL: ……..……
ALLERGIES / PAST MEDICAL HISTORY & OPERATIONS:
……
……

CONSENTS – In keeping with the PRIVACY ACT LAWS proclaimed in 2001, we require your written consent with regard to the following. Please circle: **Y or N**

I give consent for Medical information to be obtained by my doctor for the purpose of my medical treatment and passed on to third parties eg; specialists for the purpose of further treatment.	Y	N
I give consent for medical reminder letters to be sent to me at the preferred mailing address.	Y	N
I give consent for medical reminder via SMS to be sent to me at the provided mobile number.	Y	N
I give consent to release RESULTS to my designated Relative / Carer on behalf	Y	N
Relative/Carer Name:		

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 that 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 the 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. My further consent will be obtained.
I consent to the handling of my information by this practice for the purpose set out above, subject to the limitations on access or disclosure that I notify this practice of.

Signed: _____

Date: _____

Witness: _____

AGPAL QUALITY IN PRACTICE Accredited General Practice

gsmc