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| PERSONAL DETAILS INFORMATION SHEET Please fill in all relevant details as listed below (where applicable) and provide to our Receptionist once completed.  **Please present Medicare card and any other concession cards to our receptionist.** | | | | | |
| Surname: | | | Given Names: | | |
| Date of Birth: | Title:  Mr. Mrs. Ms.  Master. Miss. | | | | Gender Assigned at Birth:   Female  Male |
| Pronouns: | | | | Gender Self Identification: |
| Street Address:    Suburb:  Postcode: | | | | | |
| Mobile Phone: | | | | Home Phone: | |
| Work Phone: | |
| Email: | | | | | |
| Medicare No:  Exp. Date:  Reference No: | | DVA Number:  Type of Card.  Exp. Date: | | Pension/Healthcare Card No:  Exp. Date: | |
| Health Fund Name: | |
| Ethnicity/ Country of Origin: | | | | | |
| To assist with health initiatives - are you Aboriginal or Torres Strait Islander?  Yes - Aboriginal  Yes - Torres Strait Islander  Yes - Aboriginal & Torres Strait Islander  No  If Yes, are you registered for: CTG  Yes  No | | | | | |
| **Next of Kin** | | | | | |
| Name: | | | | | |
| Relationship: Telephone**:** | | | | | |
| **Emergency Contact (Tick if as same above)** | | | | | |
| Name: | | | | | |
| Relationship: Telephone: | | | | | |
| **How did you hear about us?** | | | | | |
| Internet Search  Family & Friends  Advertising  Other \_\_\_\_\_\_\_\_\_ \_  **Confidentiality & Privacy**  Tindale Medical Hub maintains all medical records under strict confidentiality in accordance with the Commonwealth Privacy Legislation. For more information regarding our privacy policy which includes collection of and management of your personal health information, please obtain a copy from the reception desk.  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 the reception staff if you wish to take this option.  I consent to be contacted via the following for test results, appointment confirmations, practice updates and health information.  **SMS** Yes No **Telephone** Yes No **Email:** Yes No  I agree to my health record being reviewed as a part of quality improvement activities at this practice Yes No  Signature……………………………………………………………. Date………………………… | | | | | |