Patient Information

Title: _____ **Given Name(s):** _____

Surname: _____

Preferred Name: _____

Date of Birth: _____ **Gender:** _____

Preferred Language: _____ **Occupation:** _____

Address: _____

_____ **Post Code:** _____

Telephone Numbers:

Home: _____ Work: _____

Mobile: _____

Email Address: _____

Emergency Contact Name: _____ **Relationship:** _____

Emergency Contact Phone Number: _____

Medicare No: _____ **Valid to:** _____

Position on Medicare Card: (_____) (number in front of your name on card)

DVA Pension No: _____ **Expiry Date:** _____

Centrelink Pension Concession No: _____ **Expiry Date:** _____

Name of General Practitioner (GP): _____

GP's Address (suburb only): _____

Privacy Information

In accordance with Government regulations, we are obliged to inform you that a confidential file, containing results of your tests and other relevant information will be archived by us. Routinely, information regarding the outcome of your consultations with your identifiable details (Name, DOB, Medicare Number, Contact Details) will be forwarded to your referring doctor and we may need to collect and/or send information to/from other treating doctors, specialists, allied health professionals, MHR (My Health Records) and other third parties who is involved or/and will be involved in your care.

Our preferred means of communications with you, your treating doctors, specialists, allied health professionals and other third parties who are involved or/and will be involved in your care are via efaxing, MHR (My Health Records), emails, SMS and other Medical Platform Software Provider example HealthLink.

We may need to disclose your personal information with third parties such as Medicare, Private Health Fund, our Medical Software provider/s, IT, Medical Platform Software Provider example Healthlink, eCommunication providers (efaxing, emails) to help provide you the best possible health care from us.

If a Telehealth consultation is needed, I give permission for my Doctor/s at South Sydney Medical Specialists to conduct this via telephone and/or video (Doxy me) consultation.

I have read and consented to the above Privacy Information.

Signature: _____ Date: _____