Four Corners
MEDICAL

WE DO NOT BULK BILL

PATIENT DETAILS

Title: _____ First Name: _____Surname: _____
Date of Birth: _____ Gender: [ ] Male [ ] Female [ ] Unspecified
Home Address: _____
Home Phone: _____ Consent to home phone messages: Yes / No
Mobile Phone: _____ Consent to SMS messages/Appt reminders: Yes / No
Email: _____
Occupation: _____
Marital Status: Single [ ] Defacto [ ] Married [ ] Separated [ ] Divorced [ ]

HEALTHCARE INFORMATION

Medicare Number											IRN		Exp Date:
Concession Card Number											Exp Date: / /		
DVA Number											Exp Date: / /		

Do you consent have an MHR (My Health Record) uploaded? [ ] Yes [ ] No [ ]Unsure

CULTURAL IDENTITY, MEDICAL HISTORY

Are you Aboriginal and/or Torres Strait Islander Decent? [ ]Yes-Aboriginal [ ] Yes- Torres Strait Islander [ ] Yes- Both [ ] No
Country of Birth: _____
Language Spoken: _____ Do you require an interpreter service? [ ]Yes [ ]No

Social History:	Tabacco – NO	Tobacco – Yes	Per day/week or ceased / /
	Alcohol – NO	Alcohol – Yes	Per day/week/ Month

Sexuality: _____

Health History		Hypertension		Asthma		Diabetes		Chronic Illness		Others:	

Family History

Mother:		Hypertension		Asthma		Cancer		Diabetes		Stroke		Heart Disease		N/A
Father:		Hypertension		Asthma		Cancer		Diabetes		Stroke		Heart Disease		N/A

Allergies: [ ] NO [ ] YES Please specify:_____

PARENTS/ACCOUNT PAYERS DETAILS

Parent/Carers details if the patient is under 18 years of age- (Leave blank if not applicable)

Name:		Relationship to patient:
Gender:		Date of birth:
Address: (Tick this box if it's the same)		
MEDICARE NUMBER (Tick this box if it's the same)		

NEXT OF KIN/EMERGENCY CONTACT

Name: _____ Relationship to patient: _____

Home Phone: _____ Mobile Phone: _____

PATIENT CONSENT

Your Name:	Signature:	Date:

PLEASE TURN THE PAGE TO READ OUR TERMS AND CONDITIONS

Four Corners Medical CB Pty Ltd
ABN 99 650 924 753
No 4, 201 Ferris Road, Cobblebank 3338

www.fourcornersmedical.com.au
Tel: 03 9994 0000
Fax: 03 9994 0002

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TERMS AND CONDITIONS

This medical practice collects information form you for the primary purpose of providing quality healthcare. We require you to provide us with your personal details and full medical history so that we may properly assess, diagnose, treat and be pro-active in your healthcare needs.

We may us the information you provide, in the following ways:

- Administrative purposes in running out Medical Practice
- Billing purposes, including compliances with Medicare and Health Insurance Commission requirements.
- Disclosing to others involved in your health care, including treating Doctors and Specialists outside this practice. This may occur through referrals to other Doctors, or for medical tests and in the reports returned to us following the referrals.
- Disclose to other Doctors, Allied health workers and nurses who may work in the practice, Including Locums and Accreditation Surveyors, for the purpose of patient care, teaching and accreditation.
- Disclosure for research and quality assurance activities to improve individual and community health care and practice management. This information will be De-identified.

I agree to the following:

- 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 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 rights to access the information collected about me, except in some circumstances where 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.
- By completing the section below and providing a signature, I consent to the handling of my information by this practice for the purposes set out above, subject to any limitation on access of disclosure that I notify the practice of.
- I consent or decline as indicated to receive an SMS message regarding future appointments.
- I consent or decline as indicated to messages being left on the telephone message service.
- I am aware that I will **NOT** be bulk-billed
- I am aware that there is **a NON-ATTENDANCE** fee of $30 ($50 afterhours/weekends), if I **DO NOT** give a minimum of 2 Hours' notice.

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