

KAREELA VILLAGE MEDICAL CENTRE

SHOP UL1, 1-13 FREYA ST, KAREELA 2232

TELEPHONE: (02) 9528 0711



Dear Patient,

To comply with the Government's new Privacy Legislation, we are required to gain your consent to enable us to handle personal information about you.

Please read our Privacy Policy carefully, to ensure that you agree with the manner in which we will be handling your personal information. If you are unsure about anything in either our Privacy Policy or this letter, then please ask us for clarification. Once you have read this information, please enter your name, date of birth and address on the bottom of this form and then sign it.

"I have read Kareela Village Medical Centre's Privacy Policy and I Understand the reasons why my information must be collected. I understand that I am not obliged to provide any information requested to 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 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 consent will be obtained. I consent to the handling of my information by Kareela Village Medical Centre for the purposes set out in the Privacy Policy handed to me today, subject to any limitations on access or disclosure that I notify this practice of."

Name: _____ Date of Birth: _____ Today's Date: _____

Address: _____ Signed: _____

Kareela Village Medical Centre Patient Details Form – Please Print

Title	Address	Patient's Occupation	Head of Family
Family Name	Address Line 1	Are your bank details registered with Medicare? Yes No	Name of Next of Kin
First Name	Address Line 2	Medicare Number _____	Relationship to you
Middle Name	City /Suburb	Medicare INR – Date of expiry -	Address of Next of Kin
Preferred Name	Postcode	Pension /HCC – Type – Number -	Phone Contact
Date of Birth	Postal Address	DVA No – Type -	Emergency Contact Name: Phone No:
Age	Address Line 1	Safety Net No.	If Yes- by which means do you prefer? Pls Circle- SMS? Letter? Phone?
Personal Email	Address Line 2	Country of birth/Cultural background	Do you Consent to – Update address of all family members—Pls Circle- Yes No
Birth Sex/Gender Identify	City /Suburb	Language/s Spoken	Do you Consent to: Opt out de-identified data extraction i.e.: research/quality assurance Please Circle - Yes No
Home Phone Number	Postcode	Identity as Aboriginal or Torres Strait Islander? Yes No	Do you consent to- Update address of all currently at original address Please Circle - Yes No
Mobile Phone Number	Work Phone Number	Who is responsible for your account?	<small>You will be asked to pay your account after consultation unless you are a pensioner. Please hand your Medicare card, Pension or Veteran's Affairs Card and your Driver's Licence to the Receptionist with this completed form. Thank You.</small>