

PATIENT INFORMATION FORM

PERSONAL DETAILS

Title: Surname: Given Names:

Date of birth: Country of Birth: Marital Status:

Address:

Suburb: Postcode:

Mobile: Home Phone: Work Phone:

Email:

Indigenous Status: Indigenous Torres Strait Islander Neither

Preferred method of contact: SMS Email Phone

I consent to SMS messages: YES NO

Medicare No: Ref No: Expiry:

For children under 16 years old, please provide Parent/Guardian Medicare details below:

Parent/Guardian Name:

Medicare No: *Ref No:* *Expiry:*

Do you have Private Health Insurance? YES NO

Do you have Hospital Cover? YES NO

Name of Fund: Membership Number:

When did you join your Private Health Fund?

EMERGENCY CONTACT/NEXT OF KIN

Name:

Relationship:

Mobile:

Home Phone:

REFERRAL DETAILS

Referring Doctor:

Suburb:

Usual Doctor (GP):

GP Practice Name:

Suburb:

Are you having Obstetric share care with another health professional?

YES

NO

Name:

Clinic:

Suburb:

PAYMENTS AND APPOINTMENT CANCELLATIONS

This clinic requires payment on the day of consultation. Failure to meet financial obligations may result in your account being submitted to a debt collection agency, which will incur further charges. You must advise the clinic of a cancellation at least 12 hours prior to your booked appointment.

PRIVACY AND CONSENT

Patients must give their consent (implied, oral, or written) for personal information to be collected and used as required by the Privacy Act 1988(Cth) ('Act').

I give my consent for Simply Women to collect, use and disclose my personal information, as required for the purposes of my medical treatment, as outlined by the Act.

Our Privacy Statement is available for your perusal on request.

Signature:

Date: