Beaufort Family Practice

54A Neill Street, Beaufort 3373
Phone: (03) 5336 2971 Fax: (03) 5326 1271

Title:_____Name:_____DOB:_____

Birth Sex:_____Gender Identity:_____

Ethnicity:_____ATSI Decent: YES / NO Specify:_____

Address:_____

Phone: (H):_____(M):_____(W):_____

Email Address:_____

Medicare No:_____No. Next to Name:_____Exp:_____

Pension/Health Care Card (Please Circle) No:_____Exp:_____

DVA No:_____Colour:_____

Health Fund:_____Member No:_____

Next of Kin Name:_____Relationship:_____

Next of Kin Contact Number:_____

Emergency Contact:_____Relationship:_____

Emergency Contact Number:_____

Occupation:_____Allergies:_____

Alcohol:_____Per Day/Week |Smoker:_____Per Day/Week |Ex-Smoker: Year Quit:_____

Significant Family History:_____

My Health Record

By signing this form you acknowledge that you give permission for your Doctor to upload to your eHealth/My Health Record. *If you do not consent* to the participation in MHR please tick this box ☐

By signing below you understand and agree to the following statements in relation to our use, collection, privacy and disclosure of your patient information.

I have read the information above and understand the reasons why my information must be collected, and the purposes for which my information may be used or disclosed. I understand that if my information is to be used for any purpose other than that set out above, my consent will be obtained.

I give my permission for my personal information to be collected, used and disclosed as described above (including via SMS to my mobile phone number). I understand only my relevant personal information will be provided to allow the above actions to be undertaken and I am free to withdraw, alter or restrict my consent at any time by notifying this practice in writing.

I acknowledge that I have directly requested the transfer of the health information listed below by Email. I understand and accept that the risks have been explained to me – that I have my personal information transferred without encryption – to the email address named above - and that Beaufort Family Practice staff and doctors are not responsible for the security of information once the email has been sent.

Only the documents requested will be transferred. This consent applies to those documents only.

I have read and understood the above information.

Signed: Date: