PACIFIC PINES MEDICAL CENTRE

PATIENT INFORMATION SHEET

To help our Reception staff with your details please provide the following information

Would you like to be a permanent patient at our Practice? Yes □ No □

Title: _____ Surname: _____First Name: _____ D.O.B:_____

If Child - full name of Parent: _____ D.O.B: _____

Birth Sex: Female □ Male □ Other □ Unknown □
Gender Identity: Female □ Male □ Non-Binary □ Gender Diverse □ Transgender □ Different Identity □

Do you identify as Aboriginal and/or Torres Strait Islander origin?

No □ Yes □ Aboriginal Yes □ Torres Strait Islander Yes □ Aboriginal Torres Strait Islander

Address: _____ Suburb: _____

Postcode: _____ Telephone Home: _____ Work: _____

Mobile: _____ E Mail _____

Medicare Number: _____Expiry Date: _____ Reference No: _____

Pension/HCC Card Number: _____ Expiry Date: _____

Known Allergies: _____

Do you Smoke: Yes □ No □ Ex-Smoker □ **Do you drink Alcohol: Yes □ No □ If yes how many per day: _____**

Country of Birth: _____Religion: _____

What is your preferred language? _____Cultural background: _____

Next Of Kin
Surname: _____ First Name: _____Relationship to you: _____Phone:_____

Emergency Contact
Surname: _____First Name: _____Relationship to you: _____Phone:_____

Contact
How would you like to be contacted by our Practice? (please tick your preference)
□ **Mobile** □ **Work Number** □ **Home Number** □ **SMS** □ **Email** Consent to SMS Reminders: **Yes** □ **No** □

Collection Statement & Patient Privacy
I hereby give express permission to Pacific Pines Medical Centre's staff and Doctors to receive and supply Personal Medical information from or to other Medical Practitioners/Specialists/Pathology/Radiology etc on my behalf. Your records are the property of Pacific Pines Medical Centre and will not be released without your consent. Pacific Pines Medical Centre send all our prescriptions electronically and may view the dispensing history of any of your prescriptions. I acknowledge that I am wholly responsible to arrange any further appointments to discuss my test results conducted by your Doctors on my behalf at all times. If you do not understand this information, please ask one of our receptionists to explain this to you.

Signed by and on behalf of the above listed patient: _____

My Health Record
I give permission for this practice to upload information to **My Health Record.**

HIC ONLINE
Authorisation to Lodge Patient Claims
Do you authorise this location/practice to lodge your claims electronically with Medicare and for Medicare to pass the following enrolment and benefit information to this location for verification?
* The patient's current Medicare card number
* The patient's first name and reference number
* The patient's postcode, and
* Where applicable, display the benefit amount for each service

My Health Record & HIC Online Permission - Signed: _____