

Oxford Street Medical Centre

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PATIENT CONTACT DETAILS UPDATE

Title: _____ **FIRST NAME:** _____ **INITIAL:** _____ **SURNAME:** _____

PREFERRED NAME: _____ **DOB:** ____/____/____

(Children under the age of 14, who attend this practice and also need address updated)

Child's name: _____ **DOB:** _____

Child's name: _____ **DOB:** _____

ADDRESS: _____

SUBURB: _____ **POSTCODE:** _____

MOBILE NUMBER : _____ **HOME NUMBER :** _____

EMAIL: _____ **WORK NUMBER:** _____

NEXT OF KIN DETAILS (FOR PATIENT)

Relative's Name: _____ **Phone:** _____

Relationship of Next of Kin to Patient: _____

EMERGENCY CONTACT (FOR PATIENT) Please notate "same as above" if the same as Next of Kin

Full Name: _____ **Mobile:** _____

Relationship of Emergency Contact to patient: _____

Do you have a low income Health Care Card? Yes [] No []

Card Number: - -

Expiry Date: / / (DD / MM / YYYY)

Oxford Street Medical

Patient Consent to Collect, Use and Disclose Information

As a patient of our medical practice we require you to provide us with your personal details and full medical history, so that we may properly assess, diagnose, treat and be proactive in your health care.

The Privacy Act requires medical doctors to obtain consent from their patients to collect, use and disclose the patient's personal information. Please read the notice regarding the use of your health information on waiting room wall for further details.

Please read this consent form and sign where indicated below.

- I understand that Oxford Street Medical Centre complies with the Privacy Act 1998 and are committed to collecting, using, storing and disclosing my health information in accordance with The National Privacy Principles and keep my records accurate and up-to-date.
I understand the need to communicate relevant health information to other treating doctors or Allied Health Professionals, e.g. referrals, requests for tests, to properly treat and be pro-active in your health care needs. I am also aware that this practice has a privacy policy on patient information.
- The purpose for collecting my health information is to provide quality medical care with associated account-keeping procedures in compliance with Medicare and the H.I.C.
- I understand that I can withdraw my consent for Oxford Medical Centre to use and disclose my health information, except when legal obligations have to be met. However, this action might compromise the quality of my health care and treatment given to me.
- I am aware that this practice uses a recall and reminder system to enable a systematic approach to health promotion and preventative care.
- I understand that I have the right to request access to my information, except in some circumstance where access can legitimately be denied.
- I understand that if my information is to be used for any other purpose, my further consent will be obtained.
- I consent to receive correspondence via SMS, telephone and / or post for Doctor requested appointments, appointment reminders and health information from Oxford Street Medical Centre.

Patient's Name: _____ **Date:** _____

Patient's Signature/ Guardian's Signature: _____

Tick here if your contact details have remained the same