Warragul
170 Normanby Street
Warragul 3820
Phone: (03) 56 22 33 77
Fax: (03) 56 23 60 79

Drouin
61 Commercial Place
Drouin 3818
Phone: (03) 56 25 50 44
Fax: (03) 56 25 16 55

At Central Clinic we are constantly looking for ways to improve our services to you. We appreciate patient feedback as your opinion matters to us. It is important we have updated patient details so we can efficiently communicate with you and assist with your ongoing health management.

We are asking if you could please take a few minutes to complete the details below and return to Central Clinic. You can return this form by hand, post, fax or email: reception@centralclinic.com.au

HOW DID YOU KNOW ABOUT CENTRAL CLINIC? (Please Circle) Central Clinic website / Yellow Pages / White Pages / Friend Family Member / Referring Doctor / Advert. in Paper / Advert. on Radio / Internet search / Other_____

Patient Details

Title: Mr/Mrs/Ms/Miss/Mast Surname……

Given Name/s: ……..…… Date of Birth: …../…../…… Sex: M / F

Street Address: ……..

Suburb: ……..…… State: ……. Postcode: ……

Postal Address: ……

Telephone: Home…… Work: ……..…… Mobile: ……..……..

Email Address: ……..……..……

Preferred method of contact: (Please Circle) Phone Mail

Medicare Number: …… Ref No: … ..Expiry Date: …… ./……..

DVA Number: …… Expiry: ……/……/……..

DVA Card Type (Please circle): Gold White (Condition Specific)

Pension/Healthcare Card Number:…… Expiry: ……/……../…....

MyHealth Registered (Please Circle) Yes No Do you want assistance to register? Yes No

Type of Card (Please circle): Health Care Pension Commonwealth Seniors

Ethnicity: (e.g. Aboriginal /Torres Strait Islander /Greek /Italian /Chinese)……

Occupation: ……..

Do you consent to allowing us to CONFIRM APPOINTMENTS via SMS? Yes / No

If yes please ensure your current mobile number is above.

Do you consent to having HEALTH REMINDERS mailed to you? Yes / No

Next Of Kin

Name:…… Relationship to you: ……

Address: ……..Postcode: ……

Home Telephone: ……. Work: …… Mobile: ……

Emergency Contact

Name: ……..……..…. Relationship to you: ……..……

Address: …….. Postcode: ……..

Home Telephone:…… Work: ……. Mobile: ……

Do you have any ongoing claims?

Please Circle: TAC Workcover

Claim Number: ……..……..…… Date of Injury: ……../……/……..

Employer: ……. Insurance Company: ……..

Solicitor: ……..... ……..

Address/Phone……..

Privacy Consent

In accordance with the *Privacy Act (1988)*, all information in this practice is treated as "sensitive information". To protect your privacy, this practice operates in accordance with the Act. We use the information you provide to manage your health care. You can assist in maintaining the accuracy of your information by advising the practice of changes of address, phone number, etc.

Selected information may be disclosed to various other health services involved in supporting your health care management (e.g. pathology and radiology)

Please note – Due to privacy laws it is preferred that adults and persons over sixteen years of age, arrange their own appointments whenever possible. Results **can not** be given to a third party except under special circumstances.

Consent

□ I consent to the use of my personal health information by Central Clinic and other health providers involved in my medical treatment and health care.

□ I consent to the disclosure of my personal health information by the above named practice to other health providers directly or indirectly involved in my personal health care or medical treatment.

Signature:……. Date:……/……/……..