Patient Information

This practice requires certain information from you, the patient, to enable us to provide you with an appropriate level of care and health management. If the personal information you provide us is incomplete and/or inaccurate or you choose not to provide us with this information, this may affect our ability to provide you with the necessary level of care and safety.

Surname..... Title: Mr / Mrs / Ms / Miss / Mast / Dr

First name..... Middle Name.....

Preferred name.....DOB: .....

Do you identify as being Aboriginal and/or Torres Strait Islander descent? □ Yes, (please circle) □ No

Ethnicity: ……
Residential Address: .....
Postal Address: .....

Mobile.....

Home phone..... Work phone…….....

Email ……Occupation.....

Referral Source: Former client | WOM | Internet | Other healthcare provider | Advert | Other:_____
Please give more details: (E.g. Name of person or type of ad) _____

Do you have a My Health Record (digital record)? □ Yes □ No
Do you consent to practitioners at *Thrive Medical* accessing it and uploading Health Summaries? □ Yes □ No

Medicare Number.....
Number next to your name..... Expiry ….....

□ Pension card □ Health Care card □ DVA card: Gold/White/Blue Conditions:…..... □ Other

Card number..... Expiry.....

***Please present your driver's license, Medicare card & concession cards to reception for ID purposes**

Next of kin (Full Name:)..... Mobile.....

Relationship:….....

Emergency Contact (Full Name:)..... Mobile.....

Relationship:….....

I give my permission for the practice to use the above details to send me appointment reminders via SMS text message (if you do not wish for this, you must give us an alternate means of contact such as a home / work phone or email): □ Yes □ No

Our practice undertakes research, professional development and quality assurance e/improvement activities to improve patient care. All people accessing personal health information for this purpose have signed a written confidentiality agreement.

I consent to my health record being reviewed as part of the quality improvement activities at this practice. □ Yes □ No

Our practice uses a reminder system to improve the quality of your health care. The practice sends reminders by mail or telephone for procedures such as vaccinations, pap tests and other health reviews.

I consent to being contacted with reminders as part of the quality improvement activities at this practice. □ Yes □ No

Signature:..... Date:.....