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Australia

Welcome to BITS Medical Centre.

To enable ongoing care and total quality improvement within this practice, and in keeping with the Privacy Act 1988 and National Privacy Principles, we wish to provide you with sufficient information on how your personal health information may be used or disclosed and record your consent or restrictions to this consent.

Your personal health information will only be used for the purposes for which it was collected or as otherwise permitted by law and we respect your right to determine how your personal health information is used or disclosed.

The information we collect may be collected by a number of different methods and examples may include: medical test results, notes from the consultations, Medicare and health insurance details, data collected from observations and conversations with you, and details obtained from other health care providers (e.g. specialist correspondence).

By signing below, you (as patient/guardian) are consenting, that on obtaining your personal health information it may be used or disclosed by the practice for the following purposes:

- Follow up reminder/recall notices for treatment and preventive healthcare.
- For accounting procedures and the collection of professional fees.
- The diagnosis and treatment of any health condition, including the communication of relevant information only, to practice staff, specialists and other healthcare providers to ensure quality care is provided.
- Accreditation and Quality Assurance activities are conducted by professionally trained non-treating GPs and other professionally trained and qualified persons e.g. General Practice Managers.
- For legal related disclosure as required by law.
- For use when seeking treatment by other doctors in this practice.

At all times, we are required to ensure your details are treated with the utmost confidentiality. Your records are very important and we will take all steps necessary to ensure they remain confidential.

I, _____ give my permission for my personal health information to be collected, used and disclosed as described above. I understand only my relevant personal health 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.

Patient Name: _____

Signature: _____

Date: _____

If not patient signing – your name: _____

Your relationship to patient (e.g. Mother, Father, Guardian) _____

PRACTICE USE ONLY: Witnessed by: (staff signature) _____

Patient personal details registry (each family member to complete please)

Title: Mr Mrs Ms Miss Master

Surname:

Christian Names:

Also known as:

Date of Birth:

Address:

State:

Post Code:

Home Phone:

Fax:

Work Phone:

Mobile:

Email Address:

Do you identify yourself as an Aboriginal or Torres Strait Islander person? Yes No

Medicare Number:

Expiry Date:

Ref No:

Veteran Affairs Card Number:

Expiry Date:

Pension Card Number:

Expiry Date:

Health Care Card Number:

Expiry Date:

Do you have a Government Senior's Card? Yes No

Do you have Private Health Insurance? Yes No

Marital Status: Single Married Widowed Divorced Defacto

Occupation:

Country of Birth:

Next of Kin:

Relationship:

Contact Phone Number:

Emergency Contact Name:

Contact Phone Number:

Do you have any allergies? Yes No (please specify)

Do you smoke? Yes No If so, how many times a day?

For how long?

Have you ever smoked? Yes No If so, how many times a day?

When did you quit?

Do you drink alcohol? Yes No If so, how many glasses per day?

days per week

Have you ever been pregnant? Yes No If so, how many times?

How many children do you have? female and male

Have you experienced any of the following conditions? (Please tick and specify year of onset)

Condition		Year	Condition		Year
Arthritis	<input type="radio"/> Yes <input type="radio"/> No		Heart Disease	<input type="radio"/> Yes <input type="radio"/> No	
Anaemia	<input type="radio"/> Yes <input type="radio"/> No		Heart Failure	<input type="radio"/> Yes <input type="radio"/> No	
Angina	<input type="radio"/> Yes <input type="radio"/> No		Heart Murmur	<input type="radio"/> Yes <input type="radio"/> No	
Asthma	<input type="radio"/> Yes <input type="radio"/> No		Hepatitis A, B or C	<input type="radio"/> Yes <input type="radio"/> No	
Anxiety "Nerves"	<input type="radio"/> Yes <input type="radio"/> No		History of Substance Abuse	<input type="radio"/> Yes <input type="radio"/> No	
Birth Defects	<input type="radio"/> Yes <input type="radio"/> No		HIV/AIDS	<input type="radio"/> Yes <input type="radio"/> No	
Low Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No		Kidney Problems	<input type="radio"/> Yes <input type="radio"/> No	
High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No		Liver Problems	<input type="radio"/> Yes <input type="radio"/> No	
Blood Disorders	<input type="radio"/> Yes <input type="radio"/> No		Nervous Problems	<input type="radio"/> Yes <input type="radio"/> No	
Broken Bones	<input type="radio"/> Yes <input type="radio"/> No		Pacemaker	<input type="radio"/> Yes <input type="radio"/> No	
Cancer	<input type="radio"/> Yes <input type="radio"/> No		Pneumonia	<input type="radio"/> Yes <input type="radio"/> No	
Chemotherapy	<input type="radio"/> Yes <input type="radio"/> No		Radiation Therapy	<input type="radio"/> Yes <input type="radio"/> No	
Diabetes	<input type="radio"/> Yes <input type="radio"/> No		Rheumatic Fever	<input type="radio"/> Yes <input type="radio"/> No	
Endocrine Problems	<input type="radio"/> Yes <input type="radio"/> No		Stroke	<input type="radio"/> Yes <input type="radio"/> No	
Epilepsy	<input type="radio"/> Yes <input type="radio"/> No				

If yes to any of the above questions, please give more details:

Are you aware of a family history of any of the above mentioned conditions? Yes No
If yes to the above question, please specify condition and state member of the family it applies to.

Have you undergone any surgery? Yes No (please specify)

Do you have any problems that are not mentioned on this form? Yes No (please specify)

I am aware that the information I have given is indeed needed by the doctors' surgery in order to provide the safest possible medical care and that it is treated with the strictest confidence within the practice I have answered all of the above questions honestly and am aware that I need to inform the staff of any changes at any subsequent visit. Please discuss with your doctor any medication you are taking, including herbal and alternative medicines

Your Signature _____

Date