Samy Medical Practice
Family Owned, Bulk Billing

Welcome to Samy Medical Practice-Patient Information and Consent Form

Title:	Surname:	First Name (s):	
Gender:		Date of Birth:	
Do you identify yourself as an Aboriginal or Torres Strait Islander?		Please circle: Yes or No	
Country of Birth:		Occupation:	
Address/Suburb/Postcode:			
Your Preferred Method of Contact: Home /Mobile Tel No(s):		Work Tel No:	
Email Address (If you consent to communicate through Email):			

Medicare Card No.											Ref No.		Expiry Date:

DVA/Health Care/Pension Card Number: _____Expiry Date: _____

Workers Compensation, Accident Claims, Private Drivers Medicals and Patients without a Medicare Card
Please note that you will be privately charged. If you have the claim details, please provide these information to Samy Medical Practice. It is Samy Medical Practice's policy that payment is made at the time of booking or consultation. We accept Cash, Mastercard, Visa & EFTPOS payments.

If I cannot be contacted, I authorise the following person(s) to take messages regarding a recall, reminder or appointment.

Next of Kin Details

Surname: First Names: Relationship: Tel Nos. (Home/Mobile):

Address:

Emergency Contact Details

Surname: First Names: Relationship: Tel Nos. (Home/Mobile):

Address:

Medical History: Please advise the Doctor of any diseases, current medications, allergies, family medical history or significant illnesses and your cigarette and alcohol intake.

Consent

I understand that Samy Medical Practice complies with the Privacy Act (1988) and as part of their Privacy Policy, we are committed to protecting the privacy of individuals and their personal information. The purpose for collecting my personal information is to provide quality medical and health related services and associated account keeping. I understand that I have the right to request access to my information except where access would be denied, and Samy Medical Practice makes every effort to manage my information in accordance with the National Privacy Principles and keep my records accurate and up to date. I understand that I may withdraw my consent for Samy Medical Practice to use and disclose my personal information except when legal obligations must be met.

My signature below indicates that I have read the above and consent to the following:
Samy Medical Practice collecting, using, storing and disposing of my personal information and releasing relevant personal information to other health professionals to allow quality medical care e.g. specialists and pathologist, inclusion in a recall register to be advised of follow up visits, medical updates and health information and in the case of a work-related consultation or service, the release of relevant personal information to my employer/prospective employer/insurer and their authorised representatives.

All non-bulk billed accounts will be paid at the time of consultation.

We thank you and we hope to see you again.

Name:_____Signature:_____ Date:_____