WA SPECIALIST CENTRE
OUTSTANDING SPECIALIST CARE IN WA

Patient Demographic Form

Please complete both sides and return to Reception

FIRST NAME: SURNAME:

DATE OF BIRTH: GENDER Male Female

ARE YOU OF ABORIGINAL OR TORRES STRAIT ISLANDER ORIGIN?

Yes No Rather not say

ADDRESS:

SUBURB POST CODE

HOME PHONE MOBILE

WORK PHONE EMAIL

PREFERRED METHOD OF COMMUNICATION:

EMERGENCY CONTACT NAME:

RELATIONSHIP:

ADDRESS:

WA SPECIALIST CENTRE

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CONTACT NUMBER:

MEDICARE CARD NUMBER: REF:

PENSION OR HCC NUMBER (IF APPLICABLE): EXPIRY:

USUAL GP NAME (IF DIFFERENT TO REFERRING GP):

PRACTICE:

ADDRESS:

CONTACT NUMBER:

KNOWN ALLERGIES:

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Patient Privacy Form

Consent to Collect Patient Information

This Specialist Centre collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. We will use the information you provide in the following ways:

1 Administrative purposes in running our medical practice.

2 Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.

3 Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice as advised by you.

• I understand the reasons why my information must be collected.

• I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to me.

• I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.

• I understand that if my information is to be used for any purpose other than the above, my consent will be sought.

• I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure of which I may notify this practice.

PATIENTS NAME (PLEASE PRINT):

SIGNATURE:

DATE:

Phone: +61 (08) 9592 1287 | Fax: +61 (08) 9293 4989

www.waspecialistcentre.com.au

Email: admin@waspecialistcentre.com.au