McKinley Medical Centre

433 Police Road
Mulgrave, VIC 3185
Ph (03) 9795 4011
Fax (03) 9795 2000
info@mckinleymc.com.au

PLEASE COMPLETE ALL_PAGES

We are committed to providing our patients with the best care, to do this it is essential that your medical records are up to date and accurate.

☐ I have obtained a copy of my health summary from my doctor & supplied it to McKinley Medical Centre

Could you please assist us by completing the following?

Family Name:					
Given Name					
Name Title					
Street Address:					
Suburb:		Postcode:			
Date of Birth:					
Ethnicity:					
Are you of Aboriginal or Torres Strait Islander Origin:	☐ Yes ☐ No				
Home Phone:					
Mobile Phone :					
Work Phone:					
Email :					
Consent to contact via *(please tick)*	☐ Mail ☐ Email ☐ SMS ☐ Phone - Home ☐ Phone – Work ☐ Phone – Mobile				
Medicare Number		Ref on card		Expiry Date	
DVA Gold / White (Please circle)				Expiry Date	
Pension Number				Expiry Date	
Health Care Card Number				Expiry Date	
Private Health					
Next of Kin Name Relationship Phone number Address					

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Emergency Contact (Name and Phone number of the person we can contact if needed)	

CONSENT FORM

We require your consent to collect personal information about you. Please read this consent form carefully and sign where indicated below.

This medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose, treat and be pro-active in your health care needs. This means we will use the information you provide us in the following ways.

- Administrative purposes in running our medical practice.
- Billing purposes including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your healthcare including treating doctors and specialists outside this medical practice. This may occur through the referral to other doctors, or for medical tests and in the reports or results returned to us following referrals.
- Disclosure to other doctors in the practice, locums etc. attached to the practice for the purpose of patient care and teaching. Please let us know if you do not want your records accessed for these purposes, and we note in your record accordingly.
- Disclosure for research and quality assurance activities to improve individual and community health care and practice management, all information in these instances is un-identified. These activities are ongoing within the practice. I have read the information above and understand the reasons why any information must be collected. I am also aware that this practice has a privacy policy on handling information.

I understand that I am not obliged to provide any information requested of me, but failure to do so may compromise the quality of healthcare and treatment given to me. I understand that if any information is to be used for any other purpose other than set out above, my further consent will be obtained.

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

☐ *(Please tick if agree)* I am happy to receive Appointment and/or Recall SMS text reminder messages.

Signed.....

Name.....Date.....

Signed as Guardian of child.....

Name.....