Personal Details:

Title: Surname: Given Names

Preferred Name (if applicable): Date of Birth Gender

Marital status

Single Married Defacto Separated Divorced Widowed

Are you of Aboriginal or Torress Strait Islander Origin?

No Yes, Aboriginal Yes, Torres Strait Islander Yes, Both Aboriginal and Torres Strait Islander

Medicare Number Reference Number Medicare card expiry date

Pension, Health Care Card, or Veterans Affairs Number Type of Veterans Affairs Card Expiry Date

Occupation

Home Address Postcode

Postal Adress (if different to above) Postcode

Telephone Work Mobile

Email:

EMERGNCY CONTACT:

Name: Relationship to you:

Telephone: Work: Mobile

NEXT OF KIN:

Name: Relationship to you:

Telephone: Work: Mobile:

We need this information to provide the best quality care. This form complies with the RACGP standards for general practices. This means your personal health information is kept private and secure, as required by federal and state privacy laws. If you have concerns, please leave blank and discuss with your GP. Please notify us promptly of any changes in your contact details. Accurate contact details help us identify you and your medical records, and allows us to contact you promptly about tests and results.

Consent to Medicare check:

I hereby authorise Atherton Health Hub to verify my eligibility for Medicare benefits, including accessing Medicare item numbers for care plans and mental health services that are subject to time restrictions. I understand that this verification is necessary to determine the applicability and coverage of certain Medicare benefits specific to my healthcare needs.

Options:

• ☐ Yes, I consent to the verification of my Medicare eligibility for the purposes stated above.

• ☐ No, I do not consent to the verification of my Medicare eligibility. I acknowledge that this consent allows Atherton Health Hub to perform necessary checks with Medicare to ensure eligibility and proper billing under the Medicare program.

Consent for Text Messaging:

I hereby consent to receive text messages from Atherton Health Hub for the purposes of appointment reminders, health tips, and important updates related to my care and the practice's services. I understand that text messages may be sent using an automated system and that I am not required to consent to receive text messages as a condition of receiving medical care.

Options:

• ☐ Yes, I consent to receive text messages for the purposes stated above.

• ☐ Yes, I consent to receive text messages, limited to (please tick all appropriate)
☐ Appointment
☐ Clinical Communication (Results and Clinical messaging)
☐ Clinical Reminders
☐ Health Awareness (Leaflets/database Search)

• ☐ No, I do not consent to receive text messages.

Consent for use of email:

I hereby consent to receive emails from Atherton Health Hub for the purposes of receiving newsletters, healthcare information, appointment confirmations, and updates about the practice's services. I understand that emails may contain sensitive information related to my health and treatment.

Options:

• ☐ Yes, I consent to receive emails for the purposes stated above.
• ☐ No, I do not consent to receive emails.

I acknowledge that emails may be sent over the internet and not all email services are secure. I understand the risks associated with sending and receiving information through email, including the possibility of interception by third parties. I agree to notify the practice if my email address changes.

I understand that I may revoke any of the above consents at any time by notifying the practice in writing.

Signature: _____ Date: _____

25 Louise Street, Atherton, QLD, 4883 - Ph: 07 4235 7879 - Fax: 07 4019 8008
Email: admin@athertonhealthhub.com.au - www.athertonhealthhub.com.au