prahran market clinic

UR number

patient registration

first name	known as	middle name	last name
address			gender
			date of birth
			aboriginal & torres strait islander? y: ☐ n: ☐
email			country of birth
mobile/other phone			year of arrival in australia
			cultural background

medicare number

☐☐☐☐☐☐☐☐☐☐

☐ no. by your name valid to: ☐☐ ☐☐☐☐

card sighted?

pmc staff

pension/healthcare card number

☐☐☐☐☐☐☐☐☐☐ expiry date: ____/____/_____

private health fund name & number

_____

DVA card number & colour: _____

☐☐☐☐☐☐☐☐☐☐ expiry date: ____/____/_____

student ID & faculty ? OSHC ID and expiry date

_____

emergency contact

name relationship

_____ _____

mobile/other phone

_____

Please read and sign the consent form on the other side of this page ➔

Consent to Collection of Personal Health Information

Prahran Market Clinic (PMC) requires your consent to collect personal health information. Please read the following carefully.

Personal Health Information is used by PMC to provide you with quality health care. The information that you provide will be used in the following ways:

- Administrative purposes in running this medical practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your health care, including treating doctors and other specialists both inside and outside this practice.
- Disclosure of information as required by law e.g. Notifiable diseases.

I acknowledge that I have read the information above and understand the reasons why my information must be collected.

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

I am aware of my right to access the information collected and in some circumstances where access might legitimately be withheld. I understand that I will be given an explanation in these circumstances.

I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.

Financial Consent

I acknowledge that I am liable for any fees resulting from consultations, diagnostic and therapeutic procedures.

Signature: _____ Date: ___/___/____

Entered into Genie: Date: ___/___/____

PMC Staff: _____