North East Women's Health

PATIENT INFORMATION

DR ANNA BOF & DR BETH RUSS

Surname: ____ Miss / Mrs / Ms / Dr
(As appears on your Medicare Card)

Given Names: ____

Residential Address: ____

____ Postcode: _________

Postal Address: ____

Date of Birth: ____

Phone: (Hm) _________________ (Wk) _________________ (Mob) _________________

Email: ____

Medicare #: ____________________________________ Ref #: _____ Exp: ____________
(Number in front of your name)

Do you have Private Hospital Health Cover? Yes / No

Name of Fund: ____

Membership #: ____ Ref #: ______

Type of Membership: Family / Couples / Single

Do you have an Aged Pension? Yes / No

Occupation: ____

Next of Kin Contact Number – COMPULSORY
Please provide Name / Relationship / Number

1. ____

2. ____

NORTH EAST WOMEN'S HEALTH PRIVACY POLICY - 1/09/2018

(for full details of our privacy policy please refer to our website: newh.com.au or ask to see a hard copy)

Our practice is committed to best practice in relation to the management of information we collect. This practice has developed a policy to protect patient privacy in compliance with the Privacy Act 1988 (Cth) ('the Privacy Act').

Collection of Information:

- *Your name, address, date of birth, email and contact details*
- *Medicare, Pensioner, DVA &/or Health Care Card number, Health fund details*
- *Other health information about you, including:*
  - *notes of your symptoms or diagnosis and the treatment given to you*
  - *your GP referral, specialist reports and test results*
  - *your appointment and billing details*
  - *your prescriptions*

Storage of Information:

Our staff are trained and required to respect and protect your privacy. We take steps to protect information held from misuse and loss and from unauthorised access, modification or disclosure. This includes:

- *Holding your information on an encrypted database with password security accessible only by authorised personnel*
- *Holding your information in a lockable cabine*t

Disclosure of Information:

We will correspond with your referring doctor. Copies of this correspondence may be sent to other health providers involved in your care to keep them informed of your medical condition.

Forms of Contact:

- *SMS - for reminders (eg appointment confirmation)*
- *Phone Calls - for general communication*
- *General Post*
- *Email - documents (eg medical certificates, result letters, etc)*

Signed Consent:

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

Signature of Patient:____Date:____________________

Please Print Full Name:____