# CANTERBURY FAMILY MEDICAL PRACTICE

**SUITE 2, 364 CANTERBURY ROAD, CANTERBURY NSW 2193**

**TELEPHONE: (02) 8566 3566**

**Dear Patient,**

**To comply with the Government's new Privacy Legislation, we are required to gain your consent to enable us to handle personal information about you.**

**Please read our Privacy Policy carefully, to ensure that you agree with the manner in which we will be handling your personal information. If you are unsure about anything in either our Privacy Policy or this letter, then please ask us for clarification. Once you have read this information, please enter your name, date of birth and address on the bottom of this form and then sign it.**

**"I have read Canterbury Family Medical Practice's Privacy Policy and I Understand the reasons why my information must be collected. I understand that I am not obliged to provide any information requested to 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 other purpose other than set out above, my consent will be obtained. I consent to the handling of my information by Canterbury Family Medical Practice for the purposes set out in the Privacy Policy handed to me today, subject to any limitations on access or disclosure that I notify this practice of."**

**Name:**_____ **Date of Birth:**_____ **Today's Date:**_____

**Address:**_____ **Signed:**_____

# Canterbury Family Medical Practice Patient Details Form – Please Print

| Title | Address | Patient's Occupation | Head of Family |
|---|---|---|---|
| Family Name | Address Line 1 | Are your bank details registered with Medicare? Yes No | Name of Next of Kin |
| First Name | Address Line 2 | Medicare Number<br>_____ | Relationship to you |
| Middle Name | City /Suburb | Medicare INR –<br>Date of expiry - | Address of Next of Kin |
| Preferred Name | Postcode | Pension /HCC – Type –<br>Number - | Phone Contact |
| Date of Birth | Postal Address | DVA No –<br>Type - | Emergency Contact<br>Name:<br>Phone No: |
| Age | Address Line 1 | Safety Net No. | If Yes- by which means do you prefer? Pls Circle-<br>SMS? Letter? Phone? |
| Personal Email | Address Line 2 | Country of birth/Cultural background | Do you Consent to –<br>Update address of all family members—Pls Circle- Yes No |
| Birth Sex/Gender Identify | City /Suburb | Language/s Spoken | Do you Consent to: Opt out de-identified data extraction i.e.: research/quality assurance<br>Please Circle - Yes No |
| Home Phone Number | Postcode | Identity as Aboriginal or Torres Strait Islander?<br>Yes No | Do you consent to-<br>Update address of all currently at original address<br>Please Circle - Yes No |
| Mobile Phone Number | Work Phone Number | Who is responsible for your account? | **You will be asked to pay your account after consultation unless you are a pensioner. Please hand your Medicare card, Pension or Veteran's Affairs Card and your Driver's Licence to the Receptionist with this completed form. Thank You.** |