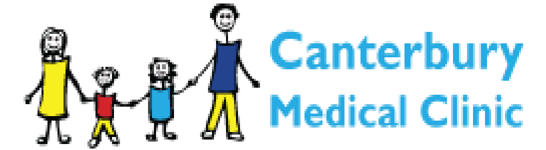
CANTERBURY MEDICAL CLINIC

215 CANTERBURY RD, CANTERBURY 3126

TELEPHONE 98362402



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 Medical Clinic'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 Medical Clinic 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:____ **Signature:**_______________________________

Canterbury Medical Clinic Patient Details Form – Please Print

Title	Address	Other information	Head of Family
Surname	Address Line 1	Occupation	Name of Next of Kin
First Name	Address Line 2	Who is responsible for your account?	Relationship to you
Middle Name	City /Suburb & Postcode	Are your bank details registered with Medicare? Yes No	Next of Kin Phone Contact
Preferred Name/ Nickname	Postal Address Line 1	Medicare Number	Name of Emergency Contact
Date of Birth	Postal Address Line 2	Medicare IRN (# next to name) – Date of expiry -	Relationship to you
Birth Sex	City/Suburb & Postcode	Pension /HCC Type – Number -	Emergency Contact Phone Contact
Gender Identity & Pronouns	Personal email	DVA Type – Number -	Do you Consent to – Update address of all family members Yes No
Country of birth/Cultural background	Home Phone Number	Safety Net No.	Do you consent to- Update address of all currently at original address Yes No
Language/s Spoken	Mobile Phone Number	Do you wish to opt out deidentified data extraction i.e.: research/quality assurance? Yes No	**You will be asked to pay your account after consultation. 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.**
Do you identity as Aboriginal or Torres Strait Islander? Yes No	Work Phone Number	Do you Consent to notifications? If Yes- by which means do you prefer? SMS Letter Phone	