

# KILMORE VILLAGE MEDICAL

Title: \_\_\_\_\_

Name: \_\_\_\_\_

Date Of Birth: \_\_\_\_\_ Email: \_\_\_\_\_

Patient Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_ Gender: \_\_\_\_\_

Occupation: \_\_\_\_\_ Ethnicity / Nationality: \_\_\_\_\_

Medicare #: \_\_\_\_\_ IRN: \_\_\_\_\_ Expiry: \_\_\_\_\_

Are you of Aboriginal or Torres strait islander origin?  Yes  No

Marital Status:  Single  Married  Divorced  Separated  Widowed  
 De-facto

I permit Kilmore Village Medical to contact me via SMS  Yes  No

I permit Kilmore Village Medical to contact me via E-mail  Yes  No

## EMERGENCY CONTACT

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Contact Details: \_\_\_\_\_ Work Phone: \_\_\_\_\_

## NEXT OF KIN CONTACT

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Contact Details: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Do you hold any of the cards below? If so, please provide details

<input type="checkbox"/> Centrelink Health Care Card	Card Number
<input type="checkbox"/> Centrelink Pension Card	_____
<input type="checkbox"/> Centrelink Senior Health Card	_____
<input type="checkbox"/> Dept. of Veteran Affairs (DVA) Gold Card	Expiry
	_____

*I understand that Kilmore Village Medical complies with the privacy and data protection act 2014 and as part of their privacy policy they are committed to protecting the privacy of individuals and their personal information. My signature below indicates that I have read the above and consent to Mernda Junction Medical collecting, using, storing and disposing of my personal information; the release of relevant personal information to other health professionals to allow quality medical care; inclusion in a recall register to be advised of follow up visits; inclusion in national/state reminder systems/registers, medical updates and health information and the release of relevant personal information to my (prospective) employer, their authorized representative and their insurer in the case of a work related consultation or service. I understand I may withdraw my consent to Mernda Junction Medical to use and disclose my personal information (except when legal obligations may be met).*

Patient's Signature: \_\_\_\_\_

How did you hear about us?  Family  Friend  Google  Hotdoc  Health Engine  
 Facebook  Instagram  Other: \_\_\_\_\_

Do you know about My Health Record?  Yes  No (If not, please ask our friendly reception staff)

Would you like our Clinical/Admin staff to register you for My Health Record  Yes  No  
(Please ask for a form to fill out from Reception)

