**Dr Marcia Bonazzi**

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| Level 1, 143 Victoria Parade  Fitzroy VIC 3065  Provider No: 211912GX | Tel: 9419 5601  Fax: 9419 5602  Email: [info@drmarciabonazzi.com.au](mailto:info@drmarciabonazzi.com.au) |

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**Patient Information**

**(Details as they appear on your Medicare Card)**

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| **Title: \_\_\_\_\_\_\_\_\_\_\_\_\_ Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Given Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Date Of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_**  **Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Suburb: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postcode: \_\_\_\_\_\_\_\_\_\_\_**  **Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Are you happy to receive email correspondence: □ Yes □ No (Please be mindful of your privacy and confidentiality)**  **Where did you hear about us: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Any Allergies (Please List): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**Billing Information**

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| **Are you happy for your records to be added to My Health Records register: □ Yes □ No**  **Medicare Number: \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ Ref No: \_\_ Pens./HCC No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Exp: \_\_\_\_\_\_\_\_\_**  **Private Health Insurance: Yes or No (If yes please complete below details)**  **Private Health Fund: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Membership No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Years of Membership: \_\_\_** |

**Referral Details:**

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| **Referring Doctor Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Referral: \_\_\_\_/\_\_\_\_/\_\_\_\_**  **Local GP Name (If different from referring doctor): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ph. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**Next of Kin Details**

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| **Next of Kin Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_** |

***Please read and sign the reverse side of this form***

We require your consent to collect personal information about your medical history. Please read the information below carefully and sign in the section at the end of this page.

All Information collected by this practice will be used for providing healthcare. Collection and ulitization and storage of this information will be compliant with the 2001 Health Records Act.

This medical clinic collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical so that we may properly assess, diagnose, treat and be practice in your health care needs. This means we will use the information you provide in the following ways:

* Administrative purposes in running our 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 specialists outside the medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals.

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I have read the information above and understand the reasons why my information must be collected. I am aware that this practice has a privacy policy on handling patient information.

I understand that I am not obliged to provide any information requested of 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 that I will be given an explanation in these circumstances.

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

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

**BILLING CONSENT & POLICY:**

I understand and acknowledge that I am responsible for payment of my consultations on the day and for all other associated medical fees for my care.

In the event that an invoice remains unpaid we will engage a debt collector to collect the debt and add any commission charged to your overall debt.

**FULL NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_\_