

Personal Information Consent Form

PERSONAL DETAILS

Title		Family Name		Given Name			
Middle Name				Preferred Name		Gender (please specify)	
Date of Birth	(Day)	(Month)	(Year)	Occupation			
Marital Status		Religion		Country of birth / Ethnicity		Indigenous status	<input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Both Aboriginal and Torres Strait Islander <input type="checkbox"/> Neither (non-Indigenous)

CONTACT DETAILS

Home Address							
	(Unit/street No)	(Street Name)					
	(Suburb)			(Post code)			
Phone (Home)	Mobile	Work phone	Preferred contact via:				
			<input type="checkbox"/> Mobile <input type="checkbox"/> Work phone <input type="checkbox"/> SMS <input type="checkbox"/> Email <input type="checkbox"/> Letter Consent to SMS reminders: <input type="checkbox"/> Yes <input type="checkbox"/> No				
Email address							

MEDICARE / OTHER DETAILS

Medicare Number		Reference (number next to name)		Expiry	
Private Health Fund				Number	
<input type="checkbox"/> Health Care Card <input type="checkbox"/> Pensioner Concession Card <input type="checkbox"/> Commonwealth Seniors Card <input type="checkbox"/> DVA					
Card Number				Expiry	

OTHER CONTACTS

Next of Kin Name				Relationship to you	
Phone (Home)		Work		Mobile	
Emergency Contact Name (if different to above)				Relationship to you	
Phone (Home)		Work		Mobile	

I have read the above information and the WA Iron Centre'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 of me, but that my failure to do so might compromise the quality of health care given to me. I consent to the handling of my information by this practice for the purpose set out in the Privacy Policy subject to any limitations on access or disclosure that I notify this practice of. I have been offered a copy of WA Iron Centre's Privacy Policy.

Signed

Name

Date