springs medical
we're here for you

Patient Information – Update Details Form

Springs Medical is currently in the process of updating patient details to ensure we have the most up to date and correct information on file. Please help us by completing the form with your updated information.

Contact information

Family Name as per Medicare			
Given Name		Preferred Name	
Title		Gender ☐ Male ☐ Female ☐ Non-binary ☐ Other	
Date of Birth			
Home address			
Postal Address ☐ Same as above			
Home Phone		Consent to home phone messages	☐ No ☐ Yes
Mobile Phone		Consent to SMS appointment reminders	☐ No ☐ Yes
Work Phone			
Email Address		Consent to email communication	☐ No ☐ Yes

Healthcare Identifiers

Medicare Number		IRN	Exp / /
DVA File Number			Exp / /
Concession (pension/healthcare) card number			Exp / /

Cultural Identity

To assist with health initiatives – are you of Aboriginal and/or Torres Strait Islander descent?

☐ Yes – Aboriginal ☐ Yes – Torres Strait Islander ☐ Yes – Both Aboriginal & Torres Strait Islander ☐ No

Country of Birth		Ethnic Background	
Languages Spoken			

Do you require an interpreter service? ☐ Yes ☐ No

Patient Status

Do you have a MHR (My Health Record)	☐ Yes	☐ No	☐ Unsure
Will you be a permanent patient at this practice?	☐ Yes	☐ No	☐ Unsure

Next of Kin

Relationship to patient:

Name		Home Phone	
Mobile Phone		Work Phone	

Emergency Contact

Relationship to patient:

Name		Home Phone	
Mobile Phone		Work Phone	

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This medical practice 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 history so that we may properly assess, diagnose, treat and be pro-active in your health care needs.

We may 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 this practice. This may occur through referral to other doctors, or for medical tests and in the reports returned to us following the referrals.
- Disclosure to other doctors, allied health workers and nurses who may work in the practice, including Locums and Accreditation Surveyors, for the purpose of patient care, teaching and accreditation.
- Disclosures for research and quality assurance activities to improve individual and community health care and practice management. This information will be de-identified.

By signing this document below, I agree to the following

- **I have read the information above and understand the reasons why my information must be collected. I am also 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 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 further consent will be obtained.**
- **By completing the section below and providing a signature, I consent to the handling of my information by this practice for the purposes set out above, subject to any limitation on access of disclosure that I notify the practice of.**
- **I consent or decline as indicated to receive an SMS message regarding future appointments**
- **I consent or decline as indicated to messages being left on telephone message service**

Patient Name

Your name (if you are not the patient) | Relationship to the patient

Signature

Date

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fax: (03) 5348 1447

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