



# Berri Medical Group



**Cornwall Street, BERRI SA 5343**

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**5 Gilbert Street, BERRI SA 5343**

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## Patient Information Form

We are committed to providing our patients with the best care. To do this it is essential that your medical records are kept up to date and accurate.

Please assist us by completing the following:

### 1. Personal Details

Date of Birth : ____/____/____		Gender: Male ____ or Female ____	
Title: Mr, Mrs, Ms, Master, Miss, _____		Status: Married / De facto / Widowed / Single	
Surname:		Given Names:	
Residential Address:			
Postal Address:			
Home Phone:	Mobile Phone:	Work Phone:	
Email:		Occupation:	

### 2. Medicare Details

Medicare Card Number:	Your Ref No on card:	Expiry Date:
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### 3. Commonwealth Concessions

Pensioner/ Health Care Card	Ref no:	Expiry:
DVA No:	Colour:	Expiry:

### 3. Emergency Contacts

Name:	Phone:	Relationship:
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### 4. Next of Kin

Name:	Phone:	Relationship:
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### 5. Ethnicity

What is your ethnicity?		
Do you identify as Aboriginal or Torres Strait Islander?	Y / N	If YES please specify:
If you are from a non- English speaking background, will you require an interpreter?	Y / N	If YES please specify:

### 6. Allergies / Smoking

Any known allergies? Food, pets, bees etc.?	Y / N	If YES please specify:		
Are you or have you ever been a smoker? Please Specify:	Non-Smoker	Smoker	Ex—Smoker	

**Information about fees:**

All healthcare services provided by this practice are covered, in part, by Medicare. We ask for full payment of your account on the day of your consultation, you are then able to claim the Medicare rebate directly from Medicare. EFTPOS facilities are available.

Workcover claims require a claim number. At the end of a Workcover consultation the account is handed to the patient for you to facilitate payment via your claim agent. For patients who do not have a Workcover claim number, full payment is expected on the day. You are then able to follow this up with your claim agent.

**Missed Appointments:**

If you are unable to keep a booked appointment, please notify the clinic immediately. We require a 4 hour notice for cancellations or a fee may apply.

**Privacy:**

Amendments to the Privacy Act came into effect in December 2001. As a provider of healthcare services it is important that you are aware of how any personal information collected by this practice is used.

The personal information collected is deemed necessary to best attend to, and treat the presenting health condition(s). Personal information primarily used within the practice, but sometimes it is used to ensure quality and continuity of healthcare for you and must be partially or fully disclosed to other outside our organization, depending on the circumstances. E.g: when referring to a specialist medical practitioner or when requesting blood tests, urine tests, x-rays etc., when itemizing accounts for Medicare or a third party.

**Freedom of Information:**

All patient files that include personal information, test results etc. are the property of the practice. However should you choose to visit another doctor at any time, copies of the appropriate file(s) can be forwarded on receipt of a written request. Under no circumstances will this practice provide or divulge personal information without your prior written consent. Please note that a small administration fee may be associated with this service.

**Please read and sign your acknowledgement below:**

I have read and understand all information provided above regarding fees, privacy and freedom of information.  
I am aware that at the conclusion of all consultations there will be a request for full payment of the account.

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

Signature: \_\_\_\_\_

Date: \_\_\_\_\_