Southern Cross Medical Centre
Cnr Stuart Ave & Fordholm Road
Hampton Park 3976
Telephone 03 97992233
Fax 03 97993006

Southern Cross Medical Centre

Personal Details **Date:** «datel»

Surname		**First name**	
Address			
Date of birth		**Telephone**	
Proposed Employer			
Proposed Position			

I hereby authorise any information regarding my pre-employment medical results to be provided to my proposed employer.

Signed: ________________________________ Date: _________________________

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Personal Details Date:_________

Surname	«surname»	**First name**	«firstname»
Address	«street1» «suburbstatepostcode»		
Date of birth	«dob»	**Telephone**	«phoneh»
Proposed Employer			
Proposed Position			

This examination is not for the purpose of determining the success of your job application, but to help prevent injury or illness in the workplace.

Personal Medical History

Please tick the box and provide details if you have ever had any of the following (write on the back page if you need more room):

Yes		Details
☐	Operations	
☐	Other times in hospital	
☐	Dermatitis/eczema/other skin problem	
☐	Fractures	
☐	Carpal tunnel syndrome	
☐	Allergy to chemicals	
☐	Epilepsy/fitting	
☐	Dizziness or blackouts	
☐	Heart Problems or chest pains	
☐	Asthma	
☐	Diabetes or thyroid problems	
☐	Arthritis or RSI tendonitis	
☐	Knee operation or arthroscopy	
☐	Hernia or bowel or bladder disea	
☐	Knee or shoulder or wrist pain	
☐	Back pain or sciatica	
☐	Depression or mental illness	
☐	Work related stress	
☐	Clots in legs or lungs	
☐	Stomach ulcer or hepatitis	

☐	Loss of hearing	
☐	Cancer/tumour	
☐	Tennis or golfers elbow	
☐	Neck pain/whiplash injury	
☐	An industrial injury or disease due to work	
☐	An injury in a motor vehicle or a motorbike accident	
☐	Are you taking any medications	

How many cigarettes do you smoke a day?		
How much alcohol do you consume a week?		
When was your last tetanus injection?	Year	
When was your last back X-ray	Year	

Declaration: I declare that all the above answers are true and correct,

Signed ______________________ Date ______________

I also authorise any information in this statement to be provided to my proposed employer.

Signed ______________________ Date ______________

PATIENT REGISTRATION

Surname:__________________________________DOB_______________
Name:_____________________________________Male Female
Mr Mrs Ms Miss Master
Address:____
Suburb: ____________________ Post Code: _______________

Phone: H) _______________ W) _______________ Mobile) __________________

Medicare No: ________________________ Exp: ____/_____ Ref No: _________

Pension /HCC No: _________________________ Exp: ______ DVA: ___________
Are You Aboriginal/Torres Strait Islander? Y N Ethnicity: __________________
Next of Kin: ______________________Relationship:________________Ph:_______________
Person responsible for account: ____
Past illness: ____
Allergies: ____

HOW YOU FOUND OUT ABOUT OUR MEDICAL CENTRE - PLEASE DETAIL

____

PATIENT PRIVACY CONSENT FORM

In accordance with National Privacy Principles, we are required to record your consent to enable us to collect and handle personal information about you. Please read the **Privacy Policy** carefully, and sign where indicated below.

Privacy Policy

This medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with accurate and up to date personal details and a full medical history so that we may safely and properly manage your health care needs.
We may use the information you provide to us in the following ways:

- By all doctors in this group practice when consulting with you
- Administrative purposes in running our practice
- For reminder / recall notices
- Billing purposes in compliance with Medicare and HIC requirements
- Disclosure to others involved in your healthcare, including specialists and other health care providers outside this medical practice. This may be in the form of referral letters and/or by collecting de-identified statistical information for clinical audits used for improved health care.
- Quality Assurance activities such as accreditation
- For disease notification as required by law (e.g. infectious diseases)
- For legal related disclosure as required by a court of law (e.g. subpoena, court order, suspected child abuse)

This medical practice complies with the National Health Privacy Principles in collection, storage and transfer of your personal information.

Patient Declaration

I have read and understood the information above.
I understand that I am not obliged to provide any information requested of me, but that failure to do so might compromise the quality of the health care given to me.
I undertake to notify the practice of changes to my personal details.
I am aware of my right to access the information collected about me, except in legitimate circumstances that will be explained to me should they arise.
I understand that if my information is to be used for any other purpose other than that set out above, my further consent will be obtained.
Any limitations that I place on the handling of my personal information, I undertake to set out in writing.

Signature:_____________

Name Printed in full: ______________________________________Date: _____________