Office use only

MIDWEST Aero Medical
ABN: 75146627107

Patient Information Form

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

Could you please assist us by completing the following:	
Title	☐Dr ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Mstr
Surname	
First Name	
Known as (preferred name)	
Date of Birth	
Are you of Aboriginal or Torres Strait Islander Origin?*	No ☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal and Torres Strait Islander ☐

Medicare Number & Reference	#:	Expiry:	Ref:
DVA Gold ☐ DVA White ☐	#:	Expiry:	
Pension Number	#:	Expiry:	
Health Care Card Number	#:	Expiry:	

Street or Postal Address	
Suburb and Post Code	
Home Phone	
Work Phone	
Mobile Phone	
Email	

Marital Status	
Occupation	
Country of Birth*	
Ethnicity*	
Language	
Next of Kin* *(Name, Relationship and Telephone Number)*	
Emergency Contact *(Name, Relationship and Telephone number of the person we can contact if needed)*	

***Must be completed**

Our practice undertakes research, professional development, and quality assurance/improvement activities to improve patient care. All people accessing personal health information for this purpose have signed a written confidentiality agreement.

I consent to my health record being reviewed as part of the quality improvement activities at this practice: †**Yes** †**No**

Our practice uses a reminder system to improve the quality of your health care. The practice sends reminders by mail, sms or telephone for procedures such as vaccinations, Pap tests and other health reviews.

I consent to being contacted with reminders as part of the quality improvement activities at this practice: †**Yes** †**No**

Midwest Aero Medical is a Private Billing Practice. I have been explained the Fee Policy and Structure
All fees are required to be paid on the day
Please initial that you have read & understand our Fee Policy and Structure **Yes / No Initial _____**

Signature of patient or guardian _____ Date _____/_____/_____