Otway Medical Clinic - Patient Information Form – Please complete in full

At the Otway Medical Clinic, 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:		
Preferred Title (if any)		
Surname		
First Name		
Date of Birth **Gender Identity** **Preferred Pronoun**	He, She, Them, Other - (Please tick or circle which)	
Street Address		
Suburb and Post Code		
Home Phone		
Work Phone		
Mobile Phone		
Email		
Medicare Number & Ref		Expiry:
o **DVA Gold** o **DVA White** (Please tick which)		Expiry:
Pension Number		Expiry:
Health Care Card Number		Expiry:
Private Health Cover YES OR NO	**Fund Name:** **Membership Number:**	
Ethnicity : **Preferred L anguage :**	**Country of Birth :**	
Next of Kin (Name and Telephone number)		
Emergency Contact (Name and Telephone number of the person we can contact if needed)		
Employer Name		
Employer Address		
Employer telephone no.		

Have you registered your bank details with Medicare?	o No o Yes.

Reminder Systems

Our practice provides our patients with preventive care and early case detection reminders e.g. immunisations, annual health checks, skin checks and pap smears.

o Yes – by Mail o Yes – by this Email_____ o Yes – by SMS this mobile phone_____	o No

If we need to contact you what is your preferred method of contact:	
o Home Phone o Mobile	o Mail o Email

Are there any health concerns that you would like to receive information on?

Patient Background

Australia is a genuinely multicultural society. To tailor appropriate care, encourage understanding and appreciation between people from different nationalities and backgrounds.

What is your country of birth ? _____

What is your Ethnicity?:

What is your Preferred Language?

To assist with health initiatives – are you an Aboriginal or Torres Strait Islander?
o No o Yes - Aboriginal o Yes - Torres Strait Islander o Yes – Aboriginal & Torres Strait Islander

Your Health History

Do you have or have you had a history of the following? (please elaborate and state the date if possible)
o Operations
o Asthma
o Diabetes
o Hypertension
o Chronic Illness
o Other

Do you have any allergies or are you sensitive to drugs or dressings?
o No o Yes. Please elaborate:

Immunisations

Have you had the following immunisations? (list date where appropriate)			
Tetanus Booster	o Yes. Date:	o No	o Don't Know
Hepatitis B	o Yes. Date:	o No	o Don't Know
Hepatitis A	o Yes. Date:	o No	o Don't Know
Influenza	o Yes. Date:	o No	o Don't Know
Pneumococcal	o Yes. Date:	o No	o Don't Know
Polio	o Yes. Date:	o No	o Don't Know
Covid-19 Vaccination	o Yes. Dates: Dose No 1 Dose No 2 Booster Doses:	o No	o Don't Know
Shingles Vaccine	o Yes. Date:	o No	o Don't Know

Children's Immunisations

If completing this form for a child are their immunisations up to date?
o Yes o No

Current Medications

Please list all current medications including over the counter medications, vitamins and minerals:

Family History

Have any members of your family had: (please elaborate)
o Heart Disease
o Asthma
o Diabetes
o Mental Illness
o Cancer
Social History – List hobbies or Interests -

Do you use any of the following: (list amount where appropriate)	
Tobacco	o No. o Yes. Number ____ day / ____ week **or** o Ceased smoking
Alcohol	o No. o Yes. Number ____ day / ____ week / ____ month
Drug Use	o No. o Yes. Type _____ / Frequency _____

Measurements-	
Height	_____ cm
Weight	_____ kg

Blood Pressure

When was the last time your blood pressure was taken?
Date : Do you know what the reading was ? ____ / ____

Sun Protection

How often do you use the following to protect yourself from the sun when outdoors?					
Protective clothing	o Always	o Often	o Sometimes	o Rarely	o Never
Sunscreen creams	o Always	o Often	o Sometimes	o Rarely	o Never

When was the last time you were immunised?			
Influenza	Date:	o Not sure	o Never
Pneumococcal pneumonia	Date:	o Not sure	o Never
Shingles Vaccine	Date:	o Not sure	o Never

Females

When did you last have?			
Pap Smear	Date:	o Not sure	o Never
Breast Check	Date:	o Not sure	o Never

Males

When did you last have?			
Overall Checkup	Date:	o Not sure	o Never

Patient Information Regarding Fees

Patient Information Regarding Fees -

The Otway Medical Clinic commenced Universal Bulk Billing on 1 November 2025.
This is for a trial period of 6-12 months.
Under Universal Bulk Billing, **all patients with a valid Medicare card are bulk billed for most Medicare consultation items.**
Please note:

- **Procedural items are privately billed.**
  These include biopsies, removal of lesions, fracture management, and venesections.
- **Skin Checks with Dr.Mira**
  These are privately billed and there is NO MEDICARE REBATE.
- **Patients must sign a claim form after each consultation.**
  This is a Medicare requirement and must be completed every time you see your GP.

We also encourage all our patients to register for **MyMedicare**, nominating **Otway Medical Clinic** as your preferred practice.
Registering helps us to provide -

1. Better continuity of care
Patients are formally linked to their preferred GP and practice, helping ensure consistent care from a team that knows their medical history well.

2. Longer & more flexible appointment options
MyMedicare supports new longer telephone consultations (for registered patients only), which can be especially helpful for people with complex or chronic conditions.

3. Better chronic disease management
Registration unlocks improved funding for GP care plans, follow-up, and coordinated care, meaning more structured support for conditions like diabetes, heart disease, asthma, and mental health needs.

4. Stronger team-based care
GPs can more easily coordinate care with nurses, allied health, hospitals, and specialists because the patient's regular practice is clearly identified.

5. More proactive care
Practices can use MyMedicare to offer recall, follow-up and preventive health support more effectively—helping avoid hospital admissions and detect issues earlier.

7. No cost to register & voluntary
Patients don't pay anything, and registration can be changed at any time.

_____
I have read the above policy and as explained to me by the Otway Clinic reception staff, I accept the responsibility of all accounts that are charged to me by the clinic.

Patient Name- (Please Print) _____

Patient Date of Birth _____

Name of Signatory, if Parent or Guardian (Please Print)

Signed _____

Date _____

Australian Privacy Principles - Health Information Collection and Use Consent Form

OTWAY MEDICAL CLINIC – 31-35 CONNOR STREET, COLAC.

As a patient of our medical practice 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 proactive in your health care needs.

We aim to protect the privacy and secure storage of your health information. **You can request a copy of our privacy policy,** which includes information about the collection, use and disclosure of your health information.

We require your consent to collect personal information about you and to use the information you provide in the following ways. Please read this consent form carefully, and sign where indicated below.

- Administrative purposes in running our medical practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your healthcare including treating doctors and specialists outside this medical practice. This may occur though referral to other doctors, or for medical tests and in the reports or results returned to us following referrals.
- Disclosure to other doctors in the practice, locums etc. attached to the practice for the purpose of patient care and teaching.
- For research and quality assurance activities to improve individual and community health care and practice management. Usually information that does not identify you is used but should information that will identify you be required you will be informed and given the opportunity to "opt out" of any involvement.
- To comply with any legislative or regulatory requirements eg notifiable diseases.
- For reminder letters which may be sent to you regarding your health care and management.

IMPORTANT:

We do prefer to communicate via SMS where possible and for this reason we like to collect your mobile phone number. If you do not wish us to send a SMS or email to communicate with you, please notify our reception staff. Your file will be flagged NO SMS and or, NO Email.

Do you consent the practice contacting you via SMS and or Email.

SMS please write YES or NO in the second column	
EMAIL please write YES or NO in the second column	

You can decline to have your health information used in all or some of the ways outlined above but it may influence our ability to manage your health care to provide the best outcome for you.

Please tick each box if you agree.

I have read the information above and understand the reasons why my information must be collected.	
I understand that I am not obliged to provide any information requested of me, but failure to do so may compromise the quality of health care and treatment given to me.	
I am aware of my rights to access the information collected about me, except in some circumstances where access may be legitimately withheld. 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.	
I consent to the handling of my information by the practice for the purpose set out above, subject to any limitations on access or disclosure of which I notify this practice.	
OR	
I am unsure and would like to discuss this further with someone from the medical practice before I sign.	

Patients Name:_____ Date: _____

Patient's signature_____

Signed as Guardian for child_____ _____ Name (printed)_____