Box Hill Family Clinic 420-422 Elgar Rd, Box Hill 3128 Vic

了解您完整的病史以及基本资料是帮助您获得良好医疗保健的关键。如果您有任何不确定的或者不知道如何填写的，请与前台或医生讨论。为了帮助我们收集以及使用您的健康信息，请在您提供您信息的同时阅读及签署病人资料同意书。

个人资料

*姓:_____名:_____*性别: 男 / 女 *生日:____ 日____月 _____ 年

*Medicare card No. _____Reference no._____ Expiry Date_____

有没 Centrelink Concession Card: 有 / 没有 私人保险公司和卡号：_____

请问你是澳州土著（Aboriginal）或者托雷斯海峡岛居民吗？ 是 / 否

*住址:_____邮编:_____

*联系电话： 家庭:_____ 工作:_____ 手机:_____

出生国家: _____ 首次到达澳大利亚年份：_____

婚姻状况(请打圈选择): 未婚 / 已婚 / 离异 / 同居 / 分居 / 丧偶 有几个孩子？_____

身高：_____ 体重：_____ 目前职业:_____

其他也在这间诊所看病的家庭成员: _____

任何监护权问题? _____

*紧急联系/近亲: 名字 _____关系_____电话_____

医疗史

*您有任何药物过敏或其它过敏源吗? 尚未发现 □ 有 □

过敏源是?_____ 过敏反应是?_____

社交方面	有	没有	曾经有过	
• 吸烟	□	□	□	每天_____支
• 饮酒	□	□	□	每周_____次
• 静脉注射药物	□	□	□	_____
• 其他非法药品（大麻）	□	□	□	_____

家族史:

您有任何亲属患过以下?	与您的关系	发病年龄	因此去世?	去世年龄
高血压 HT				
高血脂 hypercholesterolaemia				
心脏病发作/心绞痛 (IHD)				
中风 (stroke)				
哮喘/肺气肿 (asthma/COAD)				
肺结核 (TB)				
糖尿病 (DM)				
肾脏疾病 (renal disease)				
癌症				
其他				

请翻面，背面是知情同意书，须签字

Patient Consent Form

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.

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.

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_____ Guardian's Name _____