DUBBO FAMILY DOCTORS

Patient update form

We are committed to providing our patients with the best quality care. To do this it is essential that your health record is accurate. Please complete the following details.

Title:	**Surname:**	**Given Names:**

Date of Birth:	**Gender:**

Home Address:	**Post Code:**

Postal Address:	**Post Code:**

Telephone Number:	**Home:**	**Work:**	**Mobile:**

Email Address:

Consent for contact via Email or SMS:

I hereby consent to Dubbo Family Doctors contacting me via Email or SMS for

- ☐ **Appointment reminders**
- ☐ **Clinical reminders**
- ☐ **Clinical correspondence (Results & Clinical messages)**
- ☐ **Health awareness (Leaflets & Database search)**

Signature:

Medicare Card Number:	**Ref Number:**	**Expiry Date:**

Pension, Health Care Card, or Veterans Affairs Number:	**Expiry date:**

Usual Doctor:

Who can we contact in an Emergency? **Name:**	**Contact Number:** **Relationship to you:**

Next of Kin Details: **Name:**	**Contact Number:** **Relationship to you:**

Do you have an Advanced Care Directive for end of life care? Yes ☐ No ☐

For more information please talk to your GP

Please turn the page to continue

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Cultural Background:

Knowing your cultural background can help us provide healthcare that meets your individual needs.
Are you of Aboriginal or Torres Strait Islander origin?
No, Australian ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐
Yes, both Aboriginal and Torres Strait Islander ☐

Are you registered for the Closing the Gap (CTG) PBs Co-payment relief Yes ☐ No ☐
If No, please ask for further information

Other Cultural background:	**Country of Birth:**

Is English your first language? Yes ☐ No ☐ If not, do you require an interpreter? Yes ☐ No ☐

Please specify language:

IMPORTANT:
For All patients aged 16 years and over

In Accordance with Privacy Legislation we are unable to release any information either verbal or written without your consent.

1. **Do you wish to authorise a nominated person to access health information on your behalf**
   Yes ☐ No ☐
2. **Do you wish to authorise a nominated person to be able to collect Scripts/Pathology forms/Referrals & other paperwork on your behalf**
   Yes ☐ No ☐

If you ticked "Yes" to either of the above, please provide the following details for your nominated person

Name _____ Relationship to you _____

Phone contact number _____

Signature of patient or guardian_____ Date _____