MELBOURNE HEARING CARE CLINIC

Melbourne Teaching Health Clinics

THE UNIVERSITY OF MELBOURNE

PATIENT INTAKE FORM

Last Name: ______________________ First Name: ______________________

DOB: ______________________ Preferred Pronouns: ______________________

Address: ____

Phone Numer: ______________________ Email Address: ______________________

Medicare Card Number: ______________________ Expiry: ______________________

Ref Number: ____

Pension Number: ______________________ Expiry: ______________________

Health Care Card Number: ______________________ Expiry: ______________________

Prevate Health Insurance: yes/no Fund Name: ______________________

Member Number: ______________________

Are you of Aboriginal or Torres Strait Islander Origin: yes/no

Medical Professionals:

GP Name: ______________________ Phone number: ______________________

Address: ______________________ Address: ______________________

ENT Name: ______________________ ENT Name: ______________________

Address: ______________________ Address: ______________________

Other professionals (Paediatrician/Speech Pathologist/Psychologist/Teacher):

Name: ______________________ Name: ______________________

Address: ______________________ Address: ______________________

I, (print full name) ____ **give my consent for Melbourne Hearing Care to contact the professionals listed above regarding my hearing and related care.**

Signature: ____

Date: _____/_____/_____ Relationship to Patient: ______________________________
(if applicable)

CONSENT FORM - MELBOURNE HEARING CARE CLINIC RECORDS

Patient Name: ______________________________

Guardian's Name: ______________________________
(if applicable)

Melbourne Hearing Care Clinic Privacy Policy

Melbourne hearing Care Clinic complies with the Australian Privacy Principles established by the Privacy Act (1988) and Health Privacy Principles relating to health information, as specified under the Health Records Act (2002). Accordingly:

- The information we collect about you, or your dependent(s) will be used for the purpose of providing advice and treatment to you and planning of audiological care.
- Your personal and health information collected will be safeguarded and treated confidentially. You may request inspection, copies or summaries of the records kept about you and your treatment, fees may apply according to the type of access you require.
- Personal information such as name, address, date of birth, health history or family history will be used for the purposes of addressing accounts to you, writing to you about our services, or any issues concerning the treatment provided.
- With your consent we may disclose your health information to or request health information from other health care providers, if necessary, in the context of treatment.
- Your audiology records may be used for teaching purposes. All records used for teaching purposes will be de-identified and patient confidentiality will be strictly adhered to.
- You may withdraw consent at any stage by contacting Melbourne Hearing Care Clinic and this will not in any way prejudice ongoing audiological care.

We may invite you to be part of a research project or use your clinical records for research purposes conducted through the University of Melbourne. Patient confidentiality will be strictly maintained with no identifying factors if used for research activities.

☐ Only Tick this box if you do not wish for your records to be used for research purposes or do not wish to be contacted or invited to be part of a research project.

Please sign this form as confirmation that you have read and understood our privacy above.

I, (print full name) ____ have read this form and understand how my (or my child's) health records will be used and disclosed

Signature: ____

Date: _____/_____/_____

Relationship to Patient: ______________________________
(if applicable)

Melbourne Hearing Care Clinic
550 Swanston St, Carlton Victoria 3053 Australia
T: 03 9035 5333 | F: 03 9347 1535 | E: aud-reception@unimelb.edu.au | W: hearing.mthc.com.au