

Patient information

Date completed:

Patient details:

Title ☐ Mr ☐ Ms ☐ Mrs ☐ Miss ☐ Mx ☐ Dr ☐ Other:

Date of birth:

Given name(s) as shown on Medicare:

Family name as shown on Medicare:

Preferred name:

Gender ☐ Woman/female ☐ Man/male ☐ Non-binary ☐ Prefer not to answer ☐ Different term:

Pronouns (optional): ☐ She/her ☐ He/him ☐ They/them ☐ Prefer not to answer ☐ Other:

Occupation:

Interpreter required ☐ No ☐ Yes, language:

Are you of Aboriginal or Torres Strait Islander origin? (optional): ☐ No ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Prefer not to answer

Contact details:

Mobile phone:

Alternate/home phone (optional):

Email address:

Residential address:

State:

Postcode:

Postal address:

State:

Postcode:

Medicare, concession and private health details:

Medicare card:

IRN:

Expiry:

Private health insurance ☐ No ☐ Yes, fund name:

Membership number:

Concession card (optional) Type:

Number:

Expiry:

Partner or support person (optional):

First name:

Last name:

Date of birth:

Relationship to patient:

Mobile phone:

Email address:

Occupation:

Residential address:

State:

Postcode:

Medicare card (only required if requested):

IRN:

Expiry:

May the practice contact this person about appointments? ☐ No ☐ Yes

Emergency contact / next of kin:

Same as partner or support person (above): ☐ No ☐ Yes

Relationship to patient:

Full name:

Mobile phone:

Email address:

General practitioner:

Regular GP name:	Clinic name:
Clinic address / suburb:	
Referring practitioner: ☐ Same as regular GP ☐ Other:	
Referring clinic / phone:	

Regular health care team members:

Please list any other doctors and/or allied health professionals you regularly see (with their specialty & suburb):

How did you hear about us? (optional)

☐ Referring doctor ☐ Word of mouth ☐ Google ☐ Hospital website ☐ Social media ☐ Other:

Consent and acknowledgements

By signing below, I confirm that the information I have provided is accurate to the best of my knowledge and that:

Privacy and health information

I consent to the collection, use and disclosure of my personal and health information as reasonably necessary for my care and the administration of my healthcare, including communication with other healthcare providers involved in my care. I understand how my information is handled is explained in the Privacy Policy at drjamesaridas.com.au/privacy.

Obtaining health information

I authorise Dr James Aridas and his practice to request and obtain relevant health information about me from my current or previous healthcare providers where reasonably necessary for my care. I authorise those healthcare providers to release that information to Dr James Aridas and his practice.

Communication

I consent to the practice contacting me about my healthcare and the administration of my care by: ☐ SMS ☐ Phone ☐ Voicemail ☐ Email
Further information about electronic communication and privacy is available at drjamesaridas.com.au/communication.

Fees and billing

I understand that fees may apply to consultations, procedures and other services and that I am responsible for payment of applicable fees on the day of the consultation. There may be a fee for missed appointments. I have had the opportunity to review the practice's Fees and Billing Policy at drjamesaridas.com.au/fees.

AI-assisted clinical documentation

Dr James Aridas may use a secure AI-assisted documentation service during consultations to assist in preparing clinical notes and correspondence. I understand that I can decline or withdraw my consent at any time without affecting my care. Further information is available at drjamesaridas.com.au/ai.

I consent to the use of AI-assisted clinical documentation: ☐ No ☐ Yes

By signing below, I confirm that I have read and understood the above information and provide the consents and authorisations described above. I understand that I may ask questions or withdraw a consent where applicable.

Patient's Signature:	Date:
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