# MEDICAL INFORMATION AND CONSENT FORM

Patient Name: _____ Date of Birth: _____

**Contact Information:**

Address: _____

Phone Number: _____

Email: _____

**Emergency Contact:**

Name: _____

Relationship: _____

Phone Number: _____

**Medical History:**

Please provide any relevant medical history, including but not limited to chronic illnesses, allergies, past surgeries, medications currently being taken, and other pertinent information.

**Current Medications:**

_____

_____

_____

**Allergies:**

_____

_____

_____

**Consent for Medical Treatment:**

I hereby consent to receive medical examination, treatment, and care as deemed necessary by the attending medical professionals. I understand that this consent includes diagnostic procedures, administration of medications, and in emergency situations, necessary medical interventions.

**Privacy and Information Use:**

I acknowledge that any personal and medical information collected will be used and stored in accordance with the Australian Privacy Principles under the Privacy Act 1988 (Cth). My information will be treated as confidential and only disclosed to authorized personnel or as required by law.

**Patient Declaration:**

I declare that the information provided in this form is true and correct to the best of my knowledge. I understand the

contents of this form and have had the opportunity to ask questions and receive answers to my satisfaction.

| **Patient Signature** | **Practitioner Signature** |
| --- | --- |
| Signature: _____ | Signature: _____ |
| Print Name: _____ | Print Name: _____ |
| Date: _____ | Date: _____ |