

## New Patient Information Form



We are committed to providing our patients with the best care. To do this, it is essential that your health record contains complete and accurate information. Please assist us by completing your new patient record form:

### Contact Information

Gender:	Female <input type="checkbox"/> Male <input type="checkbox"/>
Title:	Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Miss <input type="checkbox"/> Mast <input type="checkbox"/> Dr <input type="checkbox"/> Other :
Surname:	
First Name:	
Date of Birth:	
Street Address:	
Postal Address: (if different to above)	
Home Phone:	
Work Phone:	
Mobile Phone:	
Email:	

### Emergency Contact Details

Name:	Relationship to you:
Address:	
Mobile Phone:	

### Next of Kin

Name:	Relationship to you:
Address:	
Mobile Phone:	

### Healthcare Identifiers

Medicare Number: _____	Ref: _____	Expiry: ___/___
Dept. of Veterans' Affairs File Number: _____	<input type="checkbox"/> Gold <input type="checkbox"/> White	
Concession (Pension/Health Care) Card Number: _____	Expiry: ___/___	

### Cultural Identity

To assist with health initiatives - are you Aboriginal and/or Torres Strait Islander?  
 No  Yes – Aboriginal  Yes - Torres Strait Islander  Yes - Aboriginal and Torres Strait Islander  
NCACCH no. \_\_\_\_\_

As Australia is a genuinely multicultural society, and to tailor appropriate care, we require the following information:

Country of birth: \_\_\_\_\_

Ethnic background: \_\_\_\_\_

Do you require an interpreter service?  No  Yes

### Reminder systems consent

I consent to receiving SMS text messages (via a third party) for:

- Appointment reminders
- Clinical reminders – for preventative care, e.g. immunisations, annual health checks, skin checks, blood tests.
- Health information – e.g. re flu clinics, vaccinations

### How did you hear about us?

- Google  Newspaper  Radio advert  Word of mouth  Letterbox flyer

## Patient Consent

**Please read this consent form carefully prior to signing.**

This general practice collects information from you for the primary purpose of providing quality health care. To enable ongoing care, and in keeping with the *Privacy Act 1988* and *Australian Privacy Principles*, we wish to provide you with sufficient information on how your personal information may be used or disclosed and record your consent or restrictions to this consent.

Your personal information will only be used for the purposes for which it was collected or as otherwise permitted by law, and we respect your right to determine how your information is used or disclosed.

The information we collect may be collected by a number of different methods and examples may include: medical test results, notes from consultations, Medicare details, data collected from observations and conversations with you, and details obtained from other health care providers (e.g. specialist correspondence).

By signing below, you (as a patient/parent/guardian) are consenting to the collection of your personal information, and that it may be used or disclosed by the practice for the following purposes:

- Administrative purposes in the operation of our general practice.
- Billing purposes, including compliance with Medicare requirements.
- Follow-up reminder/recall notices for treatment and preventative healthcare, frequently issued by SMS (by a third party) or letter.
- Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals.
- Accreditation and quality assurance activities to improve individual and community health care and practice management.
- For legal related disclosure as required by a court of law.
- For the purposes of research only where de-identified information is used.
- To allow medical students and staff to participate in medical training/teaching using only de-identified information.
- To comply with any legislative or regulatory requirements, e.g. notifiable diseases.
- For use when seeking treatment by other doctors in this practice.

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At all times we are required to ensure your details are treated with the utmost confidentiality. Your records are very important and we will take all steps necessary to ensure they remain confidential and securely stored.

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 healthcare to provide the best outcome for you.

Please complete the form below if you understand and agree to the following statements in relation to our use, collection, privacy and disclosure of your patient information.

I, \_\_\_\_\_ have read the information above and understand the reasons why my information must be collected, and the purposes for which my information may be used or disclosed. I understand that if my information is to be used for any purpose other than that set out above, my further consent will be obtained.

I, \_\_\_\_\_ give permission for my personal information to be collected, used and disclosed as described above, including contact via SMS to my mobile phone number. I understand only my relevant personal information will be provided to allow the above actions to be undertaken and I am free to withdraw, alter or restrict my consent at any time by notifying this practice in writing.

Patient name: (please print) \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If not patient signing - your name (please print) \_\_\_\_\_

Your relationship to patient (e.g. Mother, Father, guardian) \_\_\_\_\_