

NEW PATIENT INFORMATION

Please print in BLOCK LETTERS

Title (please circle): Mr / Mrs / Ms / Miss / Master/ Other _____

Surname: _____

First Name: _____

Preferred Name (if different from first name): _____

Date of Birth: ___/___/___

Gender (please circle): MALE / FEMALE

Address: _____

Suburb: _____

Postcode: _____

Home Phone: _____

Mobile Phone: _____

Email: _____

Occupation: _____

Are you Aboriginal or Torres Strait Islander (please circle): YES / NO

Ethnicity _____

Medicare Card Number _____ Ref (no. in front of name) _____ Exp _____

Please circle if you have one (or multiple) of the following as it may entitle you to reduced prescription costs:

Healthcare Card / Pension Concession Card / Senior Card / Other _____

Concession Card Number: _____ Exp. Date ___/___/___

EMERGENCY CONTACT

Surname: _____

First Name: _____

Phone: _____

Relationship: _____

PERSONAL INFORMATION

Smoking status (please circle): NON SMOKER / EX-SMOKER / SMOKER, amount per day? _____

Alcohol drinking status (please circle): NON DRINKER / DRINKER

If yes, how many times per week would you drink? _____ and how many drinks each time? _____

Allergies: NO / YES: _____

Have you had any past medical problems? NO/ YES

If YES, please specify: _____

Have you had any operations? NO / YES

If YES, please specify: _____

Which medications are you taking? _____

Vaccinations you have been given: _____

Reason for today's visit: _____

HEALTH INFORMATION COLLECTION AND USE CONSENT FORM

As a patient of our medical practice we require you to provide us with your personal details and a full medical history, so that we may properly assess, diagnose, treat and be proactive in your health care needs.

We aim to protect the privacy and secure storage of your health information. You can request a copy of our privacy policy, which includes information about the collection, use and disclosure of your health information.

We require your consent to collect personal information about you and to use the information you provide in the following ways. Please read this consent form carefully, and sign where indicated below.

- Administrative purposes in running our medical practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your healthcare 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 referrals.
- Disclosure to other doctors in the practice, locums etc. attached to the practice for the purpose of patient care and teaching.
- For research and quality assurance activities to improve individual and community health care and practice management. Usually information that does not identify you is used but should information that will identify you be required you will be informed and given the opportunity to “opt out” of any involvement.
- To comply with any legislative or regulatory requirements e.g. notifiable diseases.
- For reminder letters which may be sent to you regarding your health care and management.

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 health care to provide the best outcome for you.

I have read the information above and understand the reasons why my information must be collected.	<input type="checkbox"/>
I understand that I am not obliged to provide any information requested of me, but failure to do so may compromise the quality of health care and treatment given to me.	<input type="checkbox"/>
I am aware of my rights to access the information collected about me, except in some circumstances where access may be legitimately withheld. I will be given an explanation in these circumstances.	<input type="checkbox"/>
I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.	<input type="checkbox"/>
I consent to the handling of my information by the practice for the purpose set out above, subject to any limitations on access or disclosure of which I notify this practice.	<input type="checkbox"/>
OR	
I am unsure and would like to discuss this further with someone from the medical practice before I sign.	<input type="checkbox"/>

Patient's name: **Date:**

Patient's signature:

Signed as Guardian for child:

Name: (printed)