NEW PATIENT FORM

PLEASE PRINT CLEARLY

Please circle Mr Mrs Miss Ms Master Dr Religious Title

First Name: _____ **Middle Name:** _____

Surname: _____ **Preferred Name:** _____

Date Of Birth: _____/_____/_____ **Birth Sex:** Male/Female/Other/Unknown

Gender Identity: Female/Male/Non-binary/Transgender/Different Identity

Gender Pronoun: She, Her, Hers / He, His, Him / They, Them, Theirs

Occupation: _____

Please circle **Marital Status:** Single / Married / Widowed / Divorced / De-Facto / Separated

These cards MUST be presented to Reception

Medicare Card Number: _____ **Ref #:** _____ **Expiry Date:** _____

Please circle **Pension / HCC Number:** _____ **Expiry Date:** _____

DVA Number: _____ Gold / White Card **Expiry Date:** _____

Private Health Insurance: None / Basic Hospital / Intermediate Hospital / Top Hospital / Unsure / Extras Only

Private Health Insurance Fund Name: _____ **Membership #:** _____

Address: _____ **Suburb:** _____ **Post Code:** __

PO Box: _____ **Suburb:** _____ **Post Code:** __

Home Phone: _____ **Work Phone:** _____ **Mobile:** _____

Email: _____

Please circle **Preferred Method of Contact:** Home phone Work phone Mobile Email

Do you identify as: Aboriginal / Torres Straight Islander / Both / Neither

Cultural Background/Ethnicity: (Chinese, German etc) _____

Country of Birth: _____ **Year arrived in Australia:** _____

Preferred Language Spoken: _____

Next of Kin: _____ **Relationship:** _____ **Phone:** _____

Emergency/2nd Contact: _____ **Relationship:** _____ **Phone:** _____

Patient Signature: _____ **Date:** _____

Parent/Guardian if under the age of 16

Practice Use Only

Entered by: Staff name, signature & date: _____

PATIENT CONSENT FORM

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. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose and treat illnesses and medical conditions, ensuring we are proactive in your 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 and disclosed and record your consent or restrictions to this consent.

We require your consent to collect personal information about you and to use the information you provide in the following ways:

- Administrative purposes in running our medical practice
- Billing purposes to guarantee compliance with Medicare and the Health Insurance Commission requirements
- Follow-up reminder/recall notices for treatment and preventative healthcare
- For the purpose of sending appointment reminders for scheduled appointments
- Disclosure to others involved in your health care including treating doctors and specialists outside of this 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.
- Disclosure for statistical research and quality assurance activities to improve the individual and community health care and practice management. Please be advised that your personal details, such as your name, address and date of birth are withheld in these situations. Therefore, your identity is protected. You may elect for your information to be excluded in such activities.
- Accreditation and quality assurance activities to improve individual and community health care and practice management
- For legal related disclosure as required by the court of law
- To comply with any legislative or regulatory requirements ie: notifiable diseases

Consent to receive SMS appointment reminders from the clinic: [ ] YES [ ] NO
Consent to receive emails from the clinic: [ ] YES [ ] NO

I am aware of my right to access the information collected about me, except in circumstances where access might be withheld. I understand I will be given an explanation in these circumstances. I have been advised of the estimated costs in respect of the proposed medical services. **I accept responsibility for payment of this account, including if any nominated insurer does not pay the anticipated costs or declines liability of any injury claims.**

AUTHORITY TO RELEASE INFORMATION TO A FAMILY MEMBER OR FRIEND

I hereby give permission for the following to be released to: _____

Relationship to you: _____

Results [ ] Yes [ ] No
Medical Information [ ] Yes [ ] No
Appointment Details [ ] Yes [ ] No
Messages [ ] Yes [ ] No

Patient Name (Please Print): _____
Patient DOB: _____
Signature: _____ **Date: _____**

Practice Use Only

entered by: Staff name, signature & date: _____