New Patient Information Form - please fill in all sections and bring this to your appointment

Surname _____ **Given Names** _____

Date of Birth _____/_____/_____
dd mm yyyy

Parent's names *(if patient is under 18 years old)*

_____

Email address _____ _____

Address _____

Suburb _____ State _____ Postcode _____

Home phone _____ **Mobile** _____ **Work** _____

Medicare Number ☐☐☐☐ ☐☐☐☐☐ ☐

Number in front of your name on card ☐ *(choice of 1-9)* **Expiry date** _____/_____
mm yyyy

Veterans' Affairs Number _____ ☐ Gold Card ☐ White Card

Health conditions covered *(for white card holders)* _____

_____

Australian Pension Number *(Blue cards only)*

CRN ☐☐☐-☐☐☐-☐☐☐☐ Expiry _____/_____/_____
dd mm yyyy

Private Health Insurance

☐ Yes ☐ No Occupation _____

Emergency Contact (not next of kin) _____ Phone _____

Next of kin _____ Relationship _____ Phone _____

Names of all medication you take *(just names, not doses)* _____

_____ _____

_____ _____

Allergies _____

Former Doctor _____ _____ _____
name *clinic / practise name* *phone*

Country of birth _____ **Ethnicity** _____

Cultural background ☐ **Torres Strait Islander** ☐ **Aboriginal**

PATIENT PRIVACY CONSENT:

This Medical Practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with accurate and up to date personal details and full medical history so that we may safely and properly manage your health care needs. We may use information you provide us in the following ways:

- Administrative purposes in running our practice
- Billing purposes in compliance with Medicare Australia and HIC requirement's
- Disclosure to others involved in your health care, including specialists and other health care providers outside of our practice. This may be in the form of referral letters and/or by collecting no identifiable statistical information of clinical data for improved health care.
- To discuss your care and management with relevant providers specific to your care in case conferences between other health care providers. This Medical practice complies with National Health Privacy Principles in collection, storage and transfer of your personal information.

I HAVE READ AND UNDERSTOOD THE INFORMATION ABOVE. I UNDERSTAND THAT I AM NOT OBLIGED TO PROVIDE ANY INFORMATION REQUESTED OF ME BUT FAILURE TO DO SO MIGHT COMPROMISE THE REQUIRED HEALTH CARE GIVEN TO ME. I UNDERTAKE TO NOTIFY THE PRACTICE OF CHANGES TO MY PERSONAL DETAILS. I AM AWARE OF MY RIGHT TO ACCESS THE INFORMATION COLLECTED ABOUT ME, EXCEPT IN LEGITIMATE CIRCUMSTANCES THAT WILL BE EXPLAINED SHOULD THEY ARISE

PATIENT DECLARATION: I UNDERSTAND THAT IF MY INFORMATION IS TO BE USED FOR ANY PURPOSE OTHER THAN AS SET OUT ABOVE, MY FURTHER CONSENT WILL BE OBTAINED. ANY LIMITATION THAT I PLACE ON THE HANDLING OF MY PERSONAL INFORMATION I UNDERTAKE TO SET OUT IN WRITING.

Patients full name *(please print)* _____

Signature *(patient /guardian)* _____ **Date** _____