# NEW PATIENT INFORMATION FORM

goonellabah MEDICAL CENTRE

| TITLE: (Miss Ms Mrs Mr Dr) | FIRST NAME: | SURNAME: |
|---|---|---|
| RESIDENTIAL ADDRESS: | | POSTAL ADDRESS: |
| DATE OF BIRTH: | | I IDENTIFY MY GENDER AS: |
| HOME PHONE: | MOBILE PHONE: | WORK PHONE: |
| EMAIL ADDRESS: | | |
| OCCUPATION: | | |

**Do you indentify as being of Aboriginal or Torres Strait Islander descent?**

☐ No ☐ Yes – Aboriginal ☐ Yes - Torres Strait Islander

☐ Yes - Aboriginal and Torres Strait Islander

**Please specify any other ethnicity if applicable: _____**

| MEDICARE CARD No.: IRN: | EXPIRY DATE: |
|---|---|
| DVA CARD No.: ☐ GOLD ☐ WHITE | EXPIRY DATE: |
| CONCESSION CARD (Pension, HCC) No.: | EXPIRY DATE: |

**NEXT OF KIN**

**EMERGENCY CONTACT**
**Same as Next of Kin?** ☐ YES ☐ NO

| NAME: | NAME: |
|---|---|
| RELATIONSHIP TO PATIENT: | RELATIONSHIP TO PATIENT: |
| RESIDENTIAL ADDRESS: | RESIDENTIAL ADDRESS: |
| PHONE CONTACT: (H): (Mob): | PHONE CONTACT: (H): (Mob): |

**If these details are being completed for a child, please complete below:**

| PARENT/CARER (1): | DATE OF BIRTH: | TELEPHONE: |
|---|---|---|
| ADDRESS OF PARENT/CARER (1): | | |
| PARENT/CARER (2): | DATE OF BIRTH: | TELEPHONE: |
| ADDRESS OF PARENT/CARER (2): | | |

**How did you hear about us?** ☐ Word of mouth ☐ Website ☐ Other: _____

**NAME (Print): _____** **SIGNATURE: _____**

**OFFICE USE: DATE: _____** **DOCTOR: _____**

## New Patient Information Form
## Consent Form for Collection and Use of Health Information

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 though 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 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 messages which may be sent to you regarding your health care and management in the form of electronic communication, such as email and SMS, or by post.

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.

☐ 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.

☐ 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.

☐ 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.

☐ 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.

Patient's Name (print): _____ Date: _____

Patient's Signature: _____