New Patient Information Form/Details Update Form

Given name/s: **Last name:**

Date of birth (DD/MM/YYYY): **Preferred name:**

Sex: **Gender:** **Pronouns:**

Street address:

Postal address (if different):

Home phone: **Mobile:** **Work:**

Email address:

Is Woonona Medical Practice your usual practice? **Usual doctor:**

Occupation:

Do you need an interpreter?

If YES, please indicate preferred language:

Medicare number: **Ref #:** **Expiry:**

Card number: **Expiry:**

Department of Veteran's Affairs number: **Colour:**

We will send your claim to Medicare on your behalf. Please speak to reception if you DO NOT want your claim sent through.

Cultural Background (please tick):

- Australian, non-indigenous
- Aboriginal but not Torres Strait Islander
- Torres Strait Islander but not Aboriginal
- Both Aboriginal and Torres Strait Islander
- Other, please specify:
- Prefer not to say

If **YES** to Aboriginal or Torres Strait Islander, are you registered for the 'Close the Gap' program?

Next of Kin - Name:

Phone number: **Relationship to you:**

Emergency Contact - Name:

Phone number: **Relationship to you:**

PLEASE CONTINUE TO THE NEXT PAGE

Australian Defence Force Service (please tick):

Never served

Current Australian Defence Force – Permanent Member

Current Australian Defence Force - Reserves

Past Australian Defence Force – Permanent or Reserves

Cancellation Policy:
We ask that if you cannot make your scheduled appointment you contact us as early as possible. This ensures that other patients do not miss out on available appointments. Failure to give more than 1 hours' notice may incur a cancellation fee.

Reminder Systems:
Our practice uses a recall system for vaccinations, pap smears, health assessments/health checks and other follow up appointments. We strongly suggest that you participate in this service as these recalls are important to your health.

Would you like to be contacted via **SMS**, email and post for: **appointment reminders**, recall and other test reminders or medical services we offer?

Yes No
(Please tick)

Please sign below to acknowledge you have read and understood our cancellation policy and information regarding our reminder and recall systems.

Name: **Signature:** **Date**:

[OPTIONAL] I authorise the following person to take messages regarding making or changing an appointment and to request and collect scripts/referrals on my behalf.

Name:

Phone number: **Relationship:**

Patient signature to authorise the above:

For new patients - how did you hear about us?

PLEASE CONTINUE TO THE NEXT PAGE

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. To assist in providing a safe environment, a closed circuit television (CCTV) surveillance system has been installed in the practice (this excludes the consultation rooms).

The practice also has a privacy policy which contains information about accessing and seeking correction of personal information, privacy complaints handling process, and whether the practice is likely to disclose personal information to overseas recipients.

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, including compliance with Medicare and Health Insurance Commission requirements
- Disclosure to others involved in your healthcare and treating doctors, hospitals 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.
- Your doctor may wish to email to you specific information about your health that you have requested

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.

Please ensure you have read this consent form carefully, tick and sign where indicated below.

•	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 of the 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 purposes set out above, subject to any limitations on access or disclosure of which I notify this practice.

OR

	I am unsure and would like to discuss this further with someone from the medical practice before I sign.

Patients name: **Date**:

Patients signature:

Signed as Guardian for child: **Name:**