New Patient Information Form

Title: Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐

Surname:

Given name: Middle Name:

Preferred name:

Date of Birth: ……./……./…….

Birth Sex: ☐ Female ☐ Male ☐ Other

Gender Identity: ☐ Female ☐ Male ☐ Non-binary ☐ Gender Diverse ☐ Transgender ☐ Different Identity ☐ Prefer not to say

Pronouns: ☐ She/Her/Hers ☐ He/Him/His ☐ They/Them/Theirs ☐ Prefer not to say

Ethnicity:

What is your country of birth?

Do you identify as Aboriginal or Torres Strait Islander? Please tick:

☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal & Torres Strait Islander ☐ No

If Yes, are you registered for the Closing The Gap Program? Yes ☐ No ☐

Do you require an interpreter? Yes ☐ No ☐ Auslan? Yes ☐ No ☐

Language:

Street Address:

Postal Address (if different):

Mobile: Work Ph: Home Ph:

Email:

Medicare No: Ref No: Expiry date: ……./……./……..

DVA Gold/White number: Ref No: Expiry date ……./……./……..

Concession Card eg Pension/HCC/Seniors HHC:

Ref No: Expiry date: ……./……./……..

Next of Kin

Name: Relationship: Ph No:

Address:

Emergency contact (if different to next of kin)

Name: Relationship: Ph No:

Address:

Occupation:

Allergies - Please list all allergies (including those to medications) & describe your reaction (eg rash, vomiting, difficulty breathing).

Medicines - List all Medicines you are currently taking (including prescribed, non-prescribed, "over the counter", and "alternative" medicines).

Reminder system

Our practice supports evidence based strategies to prevent illness and detect early disease, and has a reminder system in place to do this e.g. immunisations, annual health check, skin checks, pap smears, cervical screening.

Do you wish to have any relevant health reminders sent to you by sms/email? Yes ☐ No ☐

Do you consent to sms/email appointment reminders from the surgery? Yes ☐ No ☐

Email Consent

I acknowledge and agree that, in the course of providing health care services to me, the general practice may need to use and disclose my personal information (including any health information). I acknowledge that the practice will use contact details provided by me (as updated by me from time to time) to communicate with me. I understand and consent that all email communications will be directed to that email.

Consent

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 will protect the privacy of your health information. You can request a copy of our privacy policy. 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 including treating doctors inside and outside and specialists outside this medical practice. This may include referrals, test and reports.
- 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. 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".
- 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.

Assignment of Benefit - For bulk billed appointments I assign my right to benefits to the provider who rendered the services.

Transfer of health information

You may have regularly consulted with a GP at another practice. The health information held by that practice may assist us with your future healthcare needs, so you may wish to have a copy or summary of your health records transferred to this practice. Our receptionists can assist with you with this.

Third Party Authority

Due to the Privacy Act, we need to know if at any time someone else may be collecting personal information for you, i.e. checking an appointment time or test results. If this may be the case please fill out the following section:

I authorise the person/s below to collect personal information on my behalf. This will remain valid until such time that I notify the practice otherwise, in writing.

Name: _____ Relationship to Patient: _____

- ☐ Appointment Information
- ☐ Billing Information
- ☐ Results of Investigations and Reports
- ☐ Clinical Information

I have read and understood all of the above information.

Patient signature: _____ **Date:** / /

Admin Use Only:

☐ Demographics Updated INT ☐ NOK/Emergency Updated INT ☐ Allergies/Medication Updated INT