Calamvale MEDICAL CENTRE
For all family health care

NEW PATIENT FORM

DETAILS: Title _____ First Name _____Surname_____

Known as _____

Date of birth _____/____/____ Gender: ☐ Male ☐ Female

Medicare Number _____/___ Expiry date _____

Do you have a ☐ Pension Card ☐ Health Care Card ☐ Veteran Affairs Card

Card Number _____ Expiry date _____

Individual Health Identifier Number: (only if registered) _____

Private Health Fund ☐ No ☐ Yes ☐ Basic ☐ Intermediate ☐ Top

Private Health Insurance _____ No. _____

Home Address: _____ Suburb / Postcode _____

Phone: (h) _____ (w) _____ (m) _____

Email: _____ SMS for Appointment Reminder: ☐ Yes ☐ No

Marital Status ☐ Single ☐ Married ☐ Defacto ☐ Separated ☐ Divorced ☐ Widowed

Occupation _____ Country of birth _____

Next of Kin (N.O.K.)

Name _____ Relationship to you _____

Phone: (h) _____ (w) _____ (m) _____

Emergency Contact - Same as NOK: ☐ Yes ☐ No (Please complete details below)

Name _____ Relationship to you _____

Phone: (h) _____ (w) _____ (m) _____

Are you of Aboriginal or Torres Strait Islander origin ☐ No ☐ Yes

☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal and Torres Strait Islander

Do you identify as someone from a culturally and/or linguistic diverse background?

☐ No ☐ Yes Please elaborate: _____

How did you hear about our practice?

Recommendation by: ☐ Family /friends ☐ Chemist ☐ Specialist _____

☐ Signage ☐ Mail out ☐ Internet please specify _____

☐ Local paper ☐ Yellow pages ☐ Other please specify_____

Signature of patient or guardian _____ ***Date:***_____

Office use only: Doctor Consulted (initials) _____

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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. 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, specialists and allied health providers outside this medical practice.
- 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, for example, 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 to you.

I have read the information above and understand the reasons why my information may 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 and treatment given to me.	
I am aware of my rights to access 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: ..... Date: .....

Patient's signature: .....

Signed by Parent of Guardian: .....

Name: (printed) **: .....**