

NEW PATIENT INFORMATION FORM

PLEASE HAND THIS PAGE TO THE RECEPTIONIST WHEN COMPLETED

Calamvale Medical Centre is committed to providing our patients with the best care. To do this it is essential that your health record is kept up to date and accurate.

Patient Details			
Title	<input type="checkbox"/> Dr <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Mast <input type="checkbox"/> Ms (<input type="checkbox"/> Male <input type="checkbox"/> Female)		
Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Defacto <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
Gender Identity	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary <input type="checkbox"/> Gender Diverse <input type="checkbox"/> Transgender <input type="checkbox"/> Different Identity: _____		
Surname	_____	First Name	_____
Date of Birth	_____	Preferred Name	_____
Street Address	_____		
Suburb	_____	State	_____ Postcode _____
Postal Address (if different)	_____		
Home Phone	_____	Work Phone	_____
Mobile Phone	_____		
Email	_____		
Occupation	_____		

Reminders	Consent for SMS reminders <input type="checkbox"/> Yes <input type="checkbox"/> No I understand that Calamvale Medical Centre will SMS (mobile text message) me for appointment reminders, recalls, routine reminders and health promotions. No health information is included in these SMS messages and I can opt out at any time.
-----------	--

Medicare Number	#	Ref #	Expiry:
Drives Licence Number	#	Other Identification	Details:
<input type="checkbox"/> DVA Gold <input type="checkbox"/> DVA White	#	Condition	Expiry:
Pension Card	#		Expiry:
HCC	#		Expiry:
Private Health	Name:		#
Patient Next of Kin		Relationship to you:	
Name:		Phone:	Mobile:
Emergency Contact (as above <input type="checkbox"/>) OR		Relationship to you:	
Name:		Phone:	Mobile:
Parent/Guardian Details (if patient is under 16 years of age)			
Title	<input type="checkbox"/> Dr <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss		
Surname	_____	First Name	_____
Relationship	_____	Phone	_____
Cultural Identity	To assist with health initiatives - are you of Aboriginal or Torres Strait Islander origin? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Aboriginal & Torres Strait Islander As Australia is a genuinely multicultural society, and to tailor appropriate care, encourage understanding and appreciation between people from different nationalities and cultures - do you identify as someone from a culturally and/or linguistic diverse background? <input type="checkbox"/> Yes <input type="checkbox"/> No Please specify: <input type="checkbox"/> Australian <input type="checkbox"/> Other _____ If yes, do you require an interpreter service? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Please Continue Next Page....

How did you hear about our practice?

- Signage Chemist Online booking Yellow Pages Family & Friends
- Internet – Google search please specify _____
- Specialist/GP please specify _____
- Other please specify _____

HEALTH INFORMATION COLLECTION AND USE CONSENT FORM
Please read carefully before signing

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 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 legal related disclosure as required by a court of law.
- 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 Name		Patient Signature	
Parent/Guardian		Signature	

Date	
------	--

Office Use Only: Doctor Consulted (initials) _____