NEW PATIENT INFORMATION FORM

Calamvale MEDICAL CENTRE
For all family health care

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	□ Dr □ Mr □ Mrs □ Miss □ Mast □ Ms					
Birth Sex	□ Male □ Female					
Gender Identity	□ Male □ Female □ Non-Binary □ Gender Diverse □ Transgender □ Different Identity: _____					
Pronouns	□ She/Her/Hers □ He/Him/His □ They/Them/Theirs					
Marital Status	□ Single □ Married □ Defacto □ Separated □ Divorced □ Widowed					
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 □ Yes □ 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	#	Ref #		Expiry:		
My Medicare	Would you like us to register you for My Medicare? □ Yes □ No If you would like more information please discuss with our practice team.					
Drives Licence	#	Other Identification		Details:		
□ DVA Gold □ 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 □) OR		Relationship to you:				
Name:		Phone:		Mobile:		
Parent/Guardian Details (if patient is under 16 years of age)						
Title	□ Dr □ Mr □ Mrs □ Miss					
Surname		First Name				
Relationship		Phone				
Cultural Identity	To assist with health initiatives - are you of Aboriginal or Torres Strait Islander origin? □ Yes □ No □ Aboriginal □ Torres Strait Islander □ 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? □ Yes □ No Please specify: □ Australian □ Other _____ Country of Birth: _____ *Do you require an interpreter service?* □ Yes □ 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 (November 2025): Doctor Consulted (initials) _____