GENERAL PRACTICE CREMORNE
414 Military Road
Mosman NSW 2088
Ph 8969 5000 fax 8969 5050

NEW PATIENT FORM

We are committed to providing our patients with the best care.

To do this it is essential that your medical records are up to date and accurate.

Could you please assist us by completing the following form - all grey boxes must be completed.

Surname			
First Name			
Street Address Suburb and Post Code			
Date of Birth	____ ____ /____ ____ / ____		
Are you of Aboriginal or Torres Strait Islander origin (please circle)	Yes NO		
Phone	**Home** **Mobile**	**Work Phone**	
E-mail			
Why did you choose our practice ?	**Please circle all that apply** 1) Friend/ Family referral 2) A doctor 3) Our website 4) Other please explain		
SMS Appointments /Results / Reminders (please circle)	Yes	No	
Medicare Number Patient Reference Number & Expiry Date	____ ____ ____ ____ ____ ____ ____ ____ ____ ____ Ref ____ Expiry date ____ ____ / ____ ____ ____ _____		
DVA Gold / White (War Veterans Only)		Expiry Date	
Pension Number		Expiry Date	
Government Health Care Card Number		Expiry Date	
Emergency Contact Details	Name	Relationship	Phone
Next of Kin Details	Name	Relationship	Phone

Please complete over page

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Patient Health Information Consent Form

To enable ongoing care and total quality improvement within this practice, and in keeping with the Privacy Act 1988 and Australian Privacy principles (March 2014) we wish to provide you with sufficient information on how your personal health information may be used or disclosed and record your consent or restrictions to this consent. General Practice Cremorne has a separate **Privacy Statement** available for you as a new patient and is also available in our waiting room and on the website. Your personal health information will only be used for the purposes for which it was collected or as otherwise permitted by law and we respect your right to determine how your personal health information is used or disclosed.

The information we collect may be collected by a number of different methods and examples may include: medical test results, notes from consultations, Medicare and health insurance details, data collected from observations and conversations with you, and details obtained from other health care providers (e.g. specialist correspondence).

By signing below, you (as a patient/guardian) are consenting, that on obtaining your personal contact and health information it may be used or disclosed by the practice for the following purposes:

- Appointments/follow up reminder/recall notices/results for treatment and preventive healthcare planning via letter, telephone or SMS.
- For accounting procedures and the collection of professional fees.
- The diagnosis and treatment of any health condition, including the communication of relevant information only, to practice staff, specialists and other healthcare providers to ensure quality care is provided.
- Accreditation and Quality Assurance activities are conducted by professionally trained non-treating GP's and other professionally trained and qualified persons e.g. General Practice Manager.
- For legal related disclosure as required by a court of law.
- For the purposes of research only where de-identified information is used.
- To allow medical students and staff to participate in medical training/teaching using only de-identified information.
- For disease notification as required by law.
- For use when seeking treatment by other doctors in this practice.

At all times, we are required to ensure your details are treated with the utmost confidentiality. Your records are very important and we will take all steps necessary to ensure they remain confidential.

I, _____ give my permission for my personal contact and health information to be collected, used and disclosed as described above. I understand only my relevant information will be provided to allow the above actions to be undertaken and I am free to withdraw, alter or restrict my consent at any time by notifying this practice in writing.

Patient Name: _____

Signature: _____ **Date:** _____

If Not the Patient Signing – Print Your Name: _____

Your relationship to Patient (e.g. Mother, Father, Guardian): _____

PRACTICE USE ONLY: 100 Point check met YES or NO

Witnessed by Staff Signature: _____