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 this form, all bold boxes must be completed.

Family Name			
Given Name			
Preferred Name			
Gender (Please state title – e.g. Mrs, Mr)	**Female**	**Male**	**Other**
Date of Birth	___ ___ / ___ ___ / ___ ___ ___ ___		
Home Address			
Suburb and Postcode			
Mobile Phone			
Home Phone			
Work Phone			
Preferred contact Method – Circle	**Home**	**Mobile**	**Work**
Email			
SMS Appointments/Results/Reminders	**Yes**	**No**	
Medicare Number	__ __ __ __ __ __ __ __ __ __	**Reference no.** __	
Medicare Expiry Date	___ ___ / ___ ___ ___ ___		
DVA Gold / White (if applicable)			
Are you of Aboriginal &/or Torres Strait Islander origin?	**Yes**	**No**	
Do you identify with a specific cultural background?	**Yes/No**	**Cultural Identity**	
Do you require interpreter and/or communication assistance?	**Yes/No**	**Details**	
Next of Kin (NOK) Name	**NOK Relationship**	**NOK Phone Number**	
Emergency Contact Name (different to NOK)	**Emergency Relationship**	**Emergency Contact Number**	

Patient Health Information Consent Form

To enable ongoing care and total quality improvement within our 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, which is available in our waiting room and on our 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, for example: 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 (eg. 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 reminders/recalls/results for treatment and preventative 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 that are conducted by professionally trained non-treating GP's and other professionally trained and qualified persons eg. 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.

Consent for use of information.

I confirm that the information I have given (on this form) is correct. I consent to sharing of all relevant information between the general practitioners, specialists, nurse practitioners, nurses, allied health providers and non-clinical staff for the purpose of managing my health. I understand this information will be used to fulfil their duties in the course of planning and managing my health care. 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 (eg. parent/guardian) – Your Name: _____

Your relationship to the patient: _____