All new patients are required to complete this form

Do you consent to receiving SMS communications from the Clinic?  
*SMS may include appt reminders, clinical communications (results and clinical messages) & health awareness communications:  
(Please circle appropriate Response)* YES NO

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Title:** *(please circle)* | **Mr Mrs** | **Ms Miss Other:** | | | |
| **Surname:** |  | | | | |
| **First Name:** | **Middle Name:** | | | | |
| **Preferred Name:** | **Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_** | | | | |
| **Gender:** |  | | | | |
| **Home Address:** |  | | | | |
| **Postal Address:**  **(if different to home address)** |  | | | | |
| **Phone Contact:** | **Mobile: Home/Other:** | | | | |
| **Email:** |  | | | | |
| **Occupation:** |  | | | | |
| **Medicare Number:** | **Ref No:** | | | **Expiry Date** |  |
| **Pension card or HCC** *(please circle)* | **Number:** | | | **Expiry Date** |  |
| **DVA Gold / White:** |  | | | **Expiry Date** |  |
| **Do you Have any ALLERGIES?** *(please circle)*  **YES NO** | If you circled **YES** - What are you allergic to and what is the nature of the reaction? | | | | |
| **Next of Kin:**  **Relationship to Patient:** | (Name & Telephone number) | | | | |
| **Emergency Contact:**  *(If different to Next of Kin)* | (Name and Telephone number of a person we can contact if needed) | | | | |
| **Private Health Insurance** | **Fund**:  **Membership Number:** | | | | |
| **Nationality / Place of Birth & Language spoken at home** *(if not English)* |  | | | | |
| We appreciate you answering these questions, so we can tailor care and encourage appreciation between people from different nationalities and cultural backgrounds. | If your first Language is not English, do you require an interpreter? *(Please circle your response)*  **YES** *(what Language?)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **NO** | | | | |
| **Are you Australian Aboriginal or Torres Strait Islander?**  (Please circle appropriate Response) | **YES** – Aboriginal | | **YES** – Both Aboriginal & TSI | | |
| **YES** - Torres Strait Islander | | **NO** – I am not Australian Indigenous | | |

**PATIENT CONSENT FORM**

So that we may properly assess, diagnose, treat and be proactive in your health care needs we require you to provide us with your personal details and a full medical history.   
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:

* 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 and specialists outside this medical practice. This may occur though referral to other doctors, or for medical tests and in the reports or results returned to us following referrals.
* Disclosure to other doctors in the practice, locums etc. attached to the practice for the purpose of patient care and teaching.
* For internal 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 e.g., notifiable diseases.
* For reminder letters which may be sent to you regarding your health care and management. Please read this consent form carefully, and sign where indicated below.

You can decline to have your health information used in all or some of the ways outlined above and it will not affect the care that you receive at this practice.

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| I have read the information above and understand the reasons why my information must 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 care and treatment given to me. |  |  |
| I am aware of my rights to access the 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. |  |  |
| I understand that the Clinic has expected standards of behaviour and that any aggressive, threatening, violent or abusive behaviours will not be tolerated. |  |  |

**OR**

|  |  |  |
| --- | --- | --- |
| I am unsure and would like to discuss this further with someone from the medical practice before I sign. |  |  |

**Patient’s name: ………………………………………………………………..………… Date: ……………………………………**

**Patient’s signature: ……………………………………………..………………………..…………………**

**Please return your completed from to reception.**