GUNDAGAI MEDICAL CENTRE NEW PATIENT DETAILS

CONTACT DETAILS

TITLE (please circle one)	MISS	MRS	MS	MR	MAST	Mx
FIRST NAME						
MIDDLE NAME						
SURNAME						
PREFERRED NAME						
STREET NO & NAME						
SUBURB						
STATE			**POSTCODE**			
DATE OF BIRTH						
HOME PHONE			**WORK PHONE**			
MOBILE PHONE						
EMAIL ADDRESS						
CONSENT TO RECEIVE SMS NOTIFICATIONS	YES / NO					

MEDICARE / CONCESSION CARD DETAILS ** PLEASE PRESENT CARDS TO RECEPTION STAFF **

MEDICARE NUMBER	**NO ON CARD**	**EXPIRY DATE**	
HEALTH CARE CARD		**EXPIRY DATE**	
PENSION CARD		**EXPIRY DATE**	
VETERAN AFFAIRS		**EXPIRY DATE**	
PRIVATE FUND		**NUMBER**	

MEDICARE ONLINE CLAIMING - PRIVATE PATIENTS ONLY

Do you want the practice to claim Medicare benefits on your behalf?	YES / NO

PERSONAL INFORMATION

ABORIGINAL ORIGIN	YES / NO	**TSI ORIGIN**	YES / NO	
IF ATSI - REGISTERED FOR CTG PBS CO-PAYMENT RELIEF?		YES / NO	**INTERPRETER REQUIRED**	YES/NO
COUNTRY OF BIRTH		**PRIMARY LANGUAGE**		
OCCUPATION				
EMPLOYER				

NEXT OF KIN:		**EMERGENCY CONTACT:**	
NAME OF CONTACT		**NAME OF CONTACT**	
RELATIONSHIP TO THIS PERSON		**RELATIONSHIP TO THIS PERSON**	
CONTACT PHONE		**CONTACT PHONE**	

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PATIENT HISTORY

Our practice provides our patients with preventive care and early case detection reminders e.g. immunisations, annual health checks, skin checks and cervical screening **DO YOU WISH TO HAVE ANY RELEVANT REMINDERS SENT TO YOU?**	YES - via email YES - SMS reminder NO

DO YOU HAVE ANY PREVIOUS ILLNESS OR MEDICAL CONDITIONS WE NEED TO BE AWARE OF (CIRCLE BELOW)?

eg: Diabetes, Asthma, Angina, High Blood Pressure, Varicose Veins, HIV, currently pregnant? , Hepatitis, Deep Vein thrombosis, Stomach ulcer, Skin Cancer Surgery or Bleeding Tendency

Other:_____

ALLERGIES: PLEASE LIST ALL BELOW

1	2	3	4
Other:			

YOUR HEALTH INFORMATION

To enable ongoing care and total quality improvement within this practice and in keeping with the Privacy Act (1988) and the National Privacy Principles, 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.

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 collected may be collected by a number of different methods and examples may include: medical test results, notes form 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 health information it may be used or disclosed by the practice for the following purposes:

- follow up reminder/recall notices for treatment and preventive healthcare;
- 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 GPs and other professionally trained and qualified persons, e.g. General Practice Managers;
- For legal related disclosures as required by Court of Law;
- For the purposes of research 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 health information to be collected, used and disclosed above. I understand only my relevant personal health information will be provided to allow the above actions to be undertaken and I am free to withdraw, alter to restrict my consent at any time by notifying this practice in writing.

PATIENT NAME (please print)	
SIGNATURE	
DATE	
IF NOT THE PATIENT SIGNING - YOUR NAME (please print)	