UPPER ROSS MEDICAL CENTRE

New Patient Details and Privacy Form

Title: (Please circle) Mr Mrs Miss Ms Mast Dr

Family Name: _____ **Given Name:** _____

Middle Name: _____ **Preferred Name:** _____

Date of Birth: _____ **Sex:** ☐Male ☐ Female

Do you identify as:

☐Aboriginal ☐ Torres Strait Islander ☐Both Aboriginal & Torres Strait Islander

☐Australian (non-indigenous) ☐Other (state)_____

Residential Address: _____

Suburb_____ **State:** _____ **Post Code:** _____

Phone Contact: Home: _____ **Mobile:** _____

SMS reminder (to your mobile) – do you consent? ☐**Yes** ☐**No**

Medicare Card Number:

☐☐☐☐ - ☐☐☐☐☐ - ☐ Ref no. ☐ Expiry date __/___/___

Concession/Centrelink Card Number:

☐☐☐☐☐☐☐☐☐ ☐ Expiry date __/___/___ Type: ☐ Pension ☐Healthcare

Department of Veterans' Affairs Card Number: _____

Type: ☐GOLD ☐WHITE (If White, please add condition/s) _____

Emergency Contact:

Name: _____Contact No: _____Relationship: _____

Next of Kin:

Name: _____Contact No: _____Relationship: _____

How did you hear about our practice?_____

Patient/Guardian Signature: _____Date: ___/___/___

*Please return this completed form to Reception with your **CURRENT MEDICARE CARD** and **CONCESSION CARDS**. Without these cards, there may be a PRACTICE FEE which MUST BE PAID at the end of your consultation.*

Health Information Collection and Use Consent Form

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 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 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 e.g. notifiable diseases.
- 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 for you.

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.	☐
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 : ……

Signed as Guardian for child: ……

Name: (printed) ……