



New Patient Form

Keeping you and your family in good health is our mission.

Please complete all the details in this form and return it to reception with your Medicare Card and Photo ID.

Title Mr Mrs Ms Miss Master Doctor Other

Surname **First Name**

Date of Birth / / **Gender** Male Female Other.....

Address **Suburb** **Post Code**

Mobile Number **Other Phone Number**

Email Address

Next of Kin Name

Phone Number **Relationship to You**

Emergency Contact Person Name or Same as NOK

Phone Number **Relationship to You**

Ethnicity Aboriginal Torres Strait Islander Both Australian Other

Occupation Unemployed Student Retired

Medicare **Expiry** / **Ref** (In front of your name)

Centrelink Pension or Healthcare Card **Expiry** / /

Full Time Student ID Number **Institution** **Expiry** /

DVA Gold White Orange

Do you have an electronic 'My Health Record'? Yes No Unsure

Do you consent to 'My Health Record' access and upload? Yes No

Do you consent to Appointment Reminder SMS? Yes No

Do you consent to Clinical Reminder SMS? Yes No

How did you hear about us?

Google Search Walking By Word of Mouth HealthEngine/Hotdoc Other

Book your next appointment online using Hotdoc. Download the app today.





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Patient Consent

Patients of our Medical Centre are required to provide us with your personal contact details and medical history so we may properly assess, treat and be proactive in the management of your health and wellbeing.

We provide our services within the Privacy Act 1988. Our complete Privacy Policy is available at reception or on our website. Your health information will be used only for the purposes it is collected or permitted by law.

By signing this form, you consent to your information being used for:

- Administrative purposes in running of the medical centre
- Accounting procedures and collection of professional fees
- Disclosure of medical records and health information to other doctors within our practice and affiliated practices of the group
- Communication to specialists, hospital staff, pathology labs and pharmacies involved in your medical care
- Accreditation and Quality Improvement activities with de-identified information
- Compliance with any legislative or regulatory requirements
- For clinical follow up communications by SMS, email and letters
-

Please read this consent form carefully, tick the relevant boxes and sign where indicated.

I have read the information above and understand why my details are collected	<input type="checkbox"/>
I understand I am not obliged to provide information requested by failure to do may compromise my quality of healthcare and treatment received.	<input type="checkbox"/>
I am aware of my rights to access information collected about me and the circumstances where it can be withheld.	<input type="checkbox"/>
I understand that if my information is to be used for any other purposes, my consent will be obtained	<input type="checkbox"/>
I consent to my information being handled by the medical centre as described above	<input type="checkbox"/>
I agree that if I fail to attend or give 1 hours' notice for a GP appointment, I will be required to pay a \$20 Non Attendance Fee	<input type="checkbox"/>

Patient's Name

Patient/Guardian's Signature

Date / /