KEW
GENERAL PRACTICE

New Patient Information Form

We are committed to providing our patients with the best care. To do this it is essential that your health record is kept up to date and accurate. **Could you please assist us by completing the following:**

Title	☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Mstr ☐ Other_____
Surname	
First Name	
Preferred Name	
Date of Birth	
Gender	☐ Male ☐ Female ☐ Other_____
Street Address	
Suburb and Post Code	
Home Phone	
Work Phone	
Mobile Phone	
Email	

Medicare Card Number	#:	
	Ref No:	Expiry:
☐ **DVA Gold** ☐ **DVA White** (Please tick which if relevant)	#:	Expiry:
Pension Number	#:	Expiry:
Health Care Card Number	#:	Expiry:
Private Health Cover	Name:	#:

Please turn over to page 2…

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Next of Kin	Name:
	Telephone:
	Relationship:
Emergency Contact	☐ Same as Above
	Name:
	Telephone:
	Relationship:
Your Occupation	

Reminder Systems

Do you consent to receive SMS reminders, messages and emails regarding your health, for example, appointment and immunisation reminders, recalls for results, etc?	☐ Yes ☐ No

Cultural Background

To assist with health initiatives – are you an Aboriginal or Torres Strait Islander?	☐ No ☐ Yes - Aboriginal ☐ Yes - Torres Strait Islander ☐ Yes – Aboriginal & Torres Strait Islander
Were you born in Australia?	☐ Yes ☐ No
If you were NOT born in Australia, where were you born?	
What is your ethnicity?	
Do you require an interpreting service for your consultations?	☐ Yes ☐ No
If YES, what is your preferred language?	

OFFICE USE ONLY
INITIAL: _____ DATE ENTERED: _____/_____/_____

PLEASE RETURN THIS FORM TO RECEPTION ONCE COMPLETED

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FEE AND PRIVACY CONSENT FORM

Terms & Conditions

Please read this consent form carefully prior to signing.

This general practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose and treat illnesses and medical conditions, ensuring we are proactive in your health care. To enable ongoing care, and in keeping with the *Privacy Act 1988* and Australian Privacy Principles, we wish to provide you with sufficient information on how your personal information may be used or disclosed and record your consent or restrictions to this consent.

Your personal 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 information is used or disclosed.

We may collect information using various methods and examples may include: medical test results, notes from consultations, Medicare 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/parent/guardian) are consenting to the collection of your personal information, and that it may be used or disclosed by the practice for the following purposes:

- Administrative purposes in running our general practice.
- Billing purposes, including compliance with Medicare requirements.
- Follow-up reminder/recall notices for treatment and preventative health care.
- Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals.
- Accreditation and quality assurance activities to improve individual and community health care and practice management.
- 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.
- To comply with any legislative or regulatory requirements e.g. notifiable diseases.
- 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.

By signing this form, you (as a patient/parent/guardian) are consenting to the collection, use and disclosure of your personal information as described above and to the statements below:

- I have read the information above and understand the reasons why my information must be collected, and the purposes for which my information may be used or disclosed.
- I understand that if my information is to be used for any purpose other than that set out above, my further consent will be obtained.
- I give my permission for my personal information to be collected, used and disclosed as described above including contact via SMS to my mobile phone number and/or email to the address I've provided.
- I understand that only my relevant personal 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.
- I believe the information that I have provided on this form to be true and correct.

I acknowledge that this is a mixed billing practice and I accept responsibility for payment of all associated fees.

Signed:_____

Date: _____