

New Patient Information

This information is important for you to obtain good health care. Please feel free to discuss with the reception staff or your doctor if you are unsure of anything or cannot write it down. As you are providing us with health information please also read and sign the consent form to allow us to collect and use your health information.

Personal Details Surname: _____ First Name: _____

Date of birth: ____/____/____ Title: Miss/Mrs/Ms/Mr Email: _____

Marital Status (circle): Single, Married, Engaged, Divorced, de facto, have a partner, Widowed

Address: _____ Suburb: _____

Phone Home: _____ Work: _____ Mobile: _____

Aboriginal/Torres Strait Islander: Yes/No Any Religious Affiliation: _____

Emergency contact/Next of Kin: _____ Relationship to you: _____

Contact No: _____ Ethnicity _____

Previous Doctor: _____ Contact No: _____

Address: _____

Medicare No: _____ Expiry: __/__/__ Medicare Ref No. _____

If applicable:

Pension number: _____ Expiry: __/__/__ HCC No: _____ Expiry: __/__/__

DVA card number _____ Expiry: __/__/__ Workcover Claim No: _____

Current Occupation: _____ or school _____ year _____

Any custody issues we need to be informed of: _____

Preferred Language: _____ Any special needs? _____

Appointments

Appointment times are scheduled for 15 minutes or longer if required and **can be booked on line** through our website or through the **Appointuit phone App**. If you are unable to attend an appointment please let us know within 24 hours of your appointment time.

Electronic Communication

Patient communication may be communicated via electronic means (eg SMS, Fax and email) and is conducted with appropriate regard to the Victorian Information Privacy Act 2000, the Health Records Act 2001 or the Privacy Act 1988 (Commonwealth), as applicable. Patients may be sent appointment and health promotion reminders via SMS texts and relevant information via email. South Coast Medical takes every care to ensure that electronic messages will be private.

Yes (SMS / emails)

No

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. An information brochure is available in the waiting room.

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 through 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, SMS’s or emails which may be sent to you regarding your health care and management. It is assumed you give approval unless you inform us otherwise.

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.

Patients Name _____ Date ___/___/___ Patients Signature _____

Signed as Guardian for child _____ Name (Printed) _____