New Patient Information and Privacy Consent

ST AGNES SURGERY AND TEA TREE MEDICAL

Title	☐ Mr ☐ Mrs ☐ Ms ☐ Mast ☐ Miss ☐ Dr ☐ Prof ☐ Mx ☐ Other	
Family name		
Given name/s		Preferred name
Date of birth	/ /	Gender at Birth ☐ Female ☐ Male
Street address		
Suburb		
Postal address *(if different)*	Postcode	
Contact details	M: H: W:	
Preferred contact	☐ Mobile ☐ Work ☐ Home ☐ - Yes (Consent to SMS)	
Email		

Medicare Card Number		Ref	Expiry /
Pension/ Health care card Number			Expiry /
DVA Number	☐ Gold ☐ White		Expiry /
Payer of account *(under 16 year to be linked to parent on Medicare Card)*	☐ Self ☐ Parent ☐ Guardian ☐ Other *Is the Payer of the Account a Patient of the Practice* ☐ Yes ☐ No		
Parent/ Guardian's full name and contact *(if patient is under 16 years)*	Family name Given name Phone number		

Gender Identity	☐ Female ☐ Male ☐ Non-binary ☐ Gender Diverse ☐ Transgender ☐Other (please elaborate):
Pronouns	☐ She/her/hers ☐ He/him/his ☐ They/them/theirs
Ethnicity (or country of birth)	☐ Australian ☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal & Torres Strait Islander ☐ Other (please elaborate):
How did you hear about our clinic?	☐ Family ☐ Friend ☐ Close to home/work ☐ Other health service ☐ Website ☐ Google ☐ Other
Occupation	

1st Contact Next of Kin ☐ *I do not wish to provide this information*	Family name Given name Phone number Relationship to patient
2nd Contact Emergency Contact ☐ *I do not wish to provide this information*	Family name Given name Phone number Relationship to patient

Office Use Only

Medtech Number Date Dr Code

Privacy and Information Consent Form

The Privacy Laws give you certain rights in relation to the information that you provide to this practice. Your consent is required to obtain this information. Privacy Policy is available on our website or on request at any time . Information will NOT be provided to any party for secondary purposes without your written consent.

Should you wish to allow family members to collect prescriptions and specialist referrals etc on your behalf we require you tick the appropriate box below.

(Note : The Surgery retains the right not to forward information we believe to be particularly sensitive).

PATIENT ACKNOWLEDGEMENT

I have read this form, understand and acknowledge that

- Additional information may be required to assess and treat me.
- The Privacy Policy details the use and handling of all patient information.
- Failure to provide the practice with all the information it needs may restrict its ability to provide the quality of health care.
- Have the right to access the information collected as detailed in the Privacy Policy
- Understand that if my information is to be used for any secondary purpose my further consent will be obtained.
- That a member of the practice staff has clarified any aspects of which I did not understand.
- Choose to limit access or disclosure of information and can notify the practice now or anytime in the future.
- Relevant information may be sent to secondary parties such as specialists, hospitals and other health workers on their request.

Patient Name (please print)	
Signature	Date / /

Do you consent to members of your family, or others, collecting non sensitive material on your behalf	☐ **Yes** ☐ **No**
Name	**Relationship to patient**