Entered by:_____ date:_____ ID sighted ☐

NEW PATIENT INFORMATION & CONSENT FORM

North Shore General Practice is committed to providing our patients with the very best care.

***All* the following information is required to keep your health records accurate and in line with Medicare requirements.**

SURNAME: **	****(as appears on your Medicare card)**		
FIRST NAME:		**MIDDLE NAME:**	
GENDER:	☐ **Male** ☐ **Female** ☐ **Intersex/Other** ☐ **Transgender**		
TITLE:	**Miss Mrs Ms Mstr Mr Dr Other: (please specify)**		
DATE OF BIRTH:			
STREET ADDRESS :			
SUBURB & POST CODE:			
POSTAL ADDRESS:			
Preferred Mailing Address:	(please circle) **Street / Postal**		
PHONE CONTACTS:	**Home:**	**Work:**	**Mobile:**
EMAIL:			

MEDICARE NUMBER:	**No. next to name___**	**Expiry Date:**	
Medicare GENDER:	☐ MALE ☐ FEMALE		
BLUE PENSION CARD NUMBER:		**Expiry Date:**	
HEALTH CARE CARD NUMBER:		**Expiry Date:**	
DVA GOLD CARD NUMBER:		**Expiry Date:**	
DVA WHITE CARD NUMBER:		**Expiry Date:**	
State conditions covered:			
PRIVATE HEALTH INSURANCE	☐**None** ☐**Basic Hospital** ☐**Intermediate** ☐ **Top Hospital**		

OCCUPATION:			
MARITAL STATUS:	☐**Single** ☐ **Married** ☐ **Defacto** ☐**Separated** ☐ **Divorced** ☐**Widowed**		
NEXT OF KIN:	**Name**	**Phone Number**	**Relationship To You**
EMERGENCY CONTACT:	**Name**	**Phone Number**	**Relationship To You**

DO YOU IDENTIFY AS?:	☐ **Non Indigenous** ☐ **Aboriginal** ☐ **Torres Strait Islander** ☐ **Aboriginal & Torres Strait Islander**
COUNTRY OF BIRTH:	**(Please state):** _____
WHAT IS YOUR CULTURAL BACKGROUND?:	**(Please state):** _____ **If from a non-English speaking background, what language do you speak at home?** _____

*** Please Turn Over **

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 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 identifies 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.	☐

PATHOLOGY/INVESTIGATIONS:

If your doctor orders any investigations for you, it is your responsibility to ring or come in for those results.

I agree to contact my doctor to follow up on any investigations ordered on my behalf.	☐

SMS APPOINTMENT REMINDERS

I consent to being sent appointment reminders via SMS to the mobile number provided for phone contacts:

☐ **YES** ☐ **NO**

Patient Signature: **Date:**

Parent or guardian Name *(if under 16yrs):*

Parent or guardian Signature: