

## New Patient Details

Woodend Medical Centre Pty. Ltd.

**Please Print**

Surname \_\_\_\_\_ Mr/Mrs/Miss/Ms (*please circle*)

Given Names \_\_\_\_\_ Preferred Name \_\_\_\_\_

Home Address \_\_\_\_\_

Town \_\_\_\_\_ Postcode \_\_\_\_\_

Postal Address \_\_\_\_\_

Gender:  Male  Female  Other Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Country of Birth \_\_\_\_\_

Are you of Aboriginal or Torres Strait Islander origin?

- Yes, Aboriginal  Yes, Torres Strait Islander  
 Yes, Aboriginal and Torres Strait Islander  No

Please indicate any other cultural background/s that could help us properly attend to your needs:

\_\_\_\_\_

Phone – Home ( ) \_\_\_\_\_ Phone – Work ( ) \_\_\_\_\_

Phone – Mobile \_\_\_\_\_

Do you **consent to SMS** messages being sent to you on your mobile phone?  Yes  No

*SMS messages maybe used for things like "Confirming" appointments etc...*

Email address: \_\_\_\_\_

Medicare No: \_\_\_\_/\_\_\_\_/\_\_\_\_ (10 digits) Ref # \_\_\_\_ Valid to \_\_\_\_/\_\_\_\_  
(Ref #: this is the number you are listed on your Medicare card, next to your name)

Do you have: (*please tick*)  Health Care Card  Pension

Card No: \_\_\_\_\_ Expiry Date \_\_\_\_/\_\_\_\_/\_\_\_\_

DVA No: \_\_\_\_\_ Expiry Date \_\_\_\_/\_\_\_\_ Card colour \_\_\_\_\_

**P.T.O**

Will Brooke St. Medical Centre be your usual General Practice?  Yes  No

If no, what is your usual General Practice? \_\_\_\_\_

**Who is your next of kin?**

Name \_\_\_\_\_  Male  Female  Other

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Phone: Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_ Mob \_\_\_\_\_

Relationship \_\_\_\_\_

Address \_\_\_\_\_

**Who should we contact in an emergency?**

*Please name someone with a different phone number from your own:*

Name \_\_\_\_\_  Male  Female  Other

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Phone: Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_ Mob \_\_\_\_\_

Relationship \_\_\_\_\_

Address \_\_\_\_\_

**Who is responsible for your accounts?**

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Medicare No: \_\_\_\_\_ Ref # \_\_\_\_\_ Expiry Date \_\_\_\_/\_\_\_\_/\_\_\_\_

(Reff#: this is the number you are listed on your Medicare card, next to your name)

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Postal Address \_\_\_\_\_

**Sign:**.....

**Date:**.....

OFFICE USE ONLY	
<b>Data entered by:</b> _____	<b>Date:</b> _____

**P.T.O**

## CONSENT FORM

We require your consent to collect personal information about you. Please read this information carefully, and sign where indicated below.

The Brooke Street Medical Centre 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, treat and be proactive in your health care needs. This means we will use the information you provide in the following ways:

- Administrative purposes in running our medical practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- 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.
- To contact you (or family members) for the purpose of sending Recalls and/or Reminders eg. to follow up test results, review specific health needs at timely intervals; provide health prevention information; health screens etc..

We contact patients via SMS, mail or phone call.

Patient information shall not be released to a third party without the expressed consent of the patient.

De-identified patient information from the Practice may be used for audit, accreditation and research purposes.

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I have read the information above and understand the reasons why my information is collected.

I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of health care and treatment given to me.

I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand that I will be given an explanation in these circumstances.

I understand that if my information is to be used for any purpose other than set out above; my further consent will be obtained.

I consent to the handling of my information by this practice for the purposes set out above.

**Signed** ..... **Date:** .....

**Patient Name:** ..... **Date of birth:** .....

*Please print*