



NEW PATIENT DETAILS FORM

Preferred Title: Mr Mrs Miss Ms Other (please specify)

First Name: (as on Medicare Card).....

Surname: (as on Medicare Card).....

Date of Birth:

Marital Status? (please circle) Single Married De-facto Separated/divorced Widowed

Occupation?

Address:.....**Suburb:**.....**Post Code:**.....

Phone numbers: Home:.....Work:.....Mobile:.....

Medicare Number: ----- **Position on card:** (please circle) 1 2 3 4 5 6

Social History

Do you or your family identify as Aboriginal or Torres Strait Islander? (please circle) Yes No

Would you like your cultural background recorded? (please circle) Yes No

If yes please give details of your cultural background (ie country of birth etc)

.....

Health Care Card Number: **Valid to date:**.....

Pension Card Number: **Valid to date:**.....

Next of Kin: Name..... Phone:.....

Relationship:.....

Emergency Contact: (if different from above)

Name..... Phone:.....

Relationship:.....



Carnegie Medical Centre
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Carnegie 3163
Phone: 9568 5300
Fax: 9563 0299

Consent Form

Please read this consent form carefully, and sign where indicated below.

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 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 your personal information, and for its use in the following ways:

- Administrative purposes
- Billing purposes (including compliance with Medicare and Health Insurance Commission requirements)
- Disclose to others involved in your healthcare. This includes your treating doctor 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. We also use Electronic Transfer of Prescriptions (eTP), Myhealth Record/PCEHR system as this practice participates in these eHealth services.
- Disclosure to other doctors in 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. Only information that does not identify you is used in these circumstances.
- To comply with any legislative or regulatory requirements, such as notifiable diseases.
- For reminders and recalls 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.

You have the right to deal with us anonymously or under a pseudonym unless it is impracticable for us to do so or unless we are required or authorized by law to only deal with identified individuals.

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.

I understand that, at Carnegie Medical Centre my rights to privacy are protected under the *Privacy Act 1988* and the *Privacy Amendment (private Sector) Act 2000*. With this knowledge I give permission to be contacted through electronic means provided by myself or by the person in charge of my care. I allow the health information of the person in this registration form to be collected, used, disclosed or shared to enable the primary purpose of ongoing care and the secondary purpose of quality improvement, population health planning, and research. This may include, accounting procedures for account management, diagnosis and treatments, Quality Assurance, general practice accreditation, legal disclosures required by a court of law, population health planning, research, medical training/teaching, for seeking treatment by other medical practitioners in the practice and or disease notification as require by law. The information may be collected through medical test results, consultation notes, Medicare and health insurance details, specialists' correspondence and/or relevant sources.

Carnegie Medical Centre participates, collects and complies with all the Australian Digital Health Authority (ADHA) initiatives for electronically connecting the points of care so that your health information can be shared securely. We do so to help in facilitating to a connected system where every Australian is at the centre of their own healthcare.

I CONSENT TO SMS TEXT MESSAGES FOR APPOINTMENT AND HEALTH REMINDERS

I agree to all of the above:

Patient Name: **Date:**/...../20.....

Patient Signature:

Signed as Guardian for child:

Name of Guardian: (printed)