New Patient Form -

MOUNT SHERIDAN MEDICAL PRACTICE

We are committed to providing our patients with the best care. To do this, it is essential that your personal information is up to date and accurate.

Title: Mr, Mrs, Miss, Ms, Master		
Surname:	First Name:	Middle Name:
Date of Birth:	Gender Assigned at birth: Male / Female / Other	Gender Identity: Male / Female / Transgender / Gender diverse / Non-binary / Different Identity
Preferred Pronouns: She / Her / Hers | He / Him / His | They / Them Theirs		
Residential Address:		
Postal Address: Tick if same as above □		
Mobile Phone:	Home Phone:	Work Phone:
Email:		
Medicare Card Number:	Ref:	Exp:
Pension/Concession Card:		Exp:
DVA: White □ Gold □ Number:		Occupation:
IN THE EVENT OF AN EMERGENCY, WHO WOULD BE YOUR FIRST CONTACT PERSON:		

Next of Kin:	Emergency Contact: If same as Next of Kin: Yes □ No □
Name:	Name:
Address:	Address:
Relationship to patient:	Relationship to patient:
Contact Number:	Contact Number:

Cultural Background	
Australia is a genuinely multicultural society. To tailor appropriate care, encourage understanding and appreciation between people from different nationalities and backgrounds, knowing your cultural background can help us provide healthcare that meets your individual needs.	
Do you identify as being of Aboriginal or Torres Strait islander? □ No □ Yes, Aboriginal □ Yes, Torres Strait Islander □Yes, Both Aboriginal and Torres Strait Island	
Cultural background (Ethnicity):	Country of Birth:
Is English your First Language? □ Yes □ No	
If not, do you require an interpreter? □ Yes □ No If Yes, please specify language:	

REMINDER SYSTEM & CONSENT: Our practice provides our patients with preventive care and early case detection reminders e.g., immunisations, annual health check, skin check and pap smears.

DO YOU CONSENT TO HAVING YOUR HEALTH REMINDERS SENT TO YOU BY MAIL? Yes /No

DO YOU CONSENT TO SMS CONTACT/REMINDERS FROM THE SURGERY? Yes /No

DO YOU CONSENT TO EMAIL COMMUNICATION AND THE TRANSMISSION OF PERSONAL HEALTH INFORMATION VIA STANDARD UNENCRYPTED EMAIL? Yes /No

Patients Signature _____Date: _____

Health Information Collection and Use Consent Form

MOUNT SHERIDAN MEDICAL PRACTICE

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 though 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 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.	□

Patients Signature: …… Date: …….

Or Signed as Parent/Guardian for child: ……

Name of patient if signing on behalf of child: (printed) …….

What led you to choosing our practice for your care today… Family/ Friend Recommendation Live in the Area Online Search Coconut Resort/Caravan Park Facebook Other……