Welcome to Belgian Gardens Medical Centre

New Patient Information Form

Title (please circle)	Mr Mrs Ms Miss Master	Relationship Status: (please circle)	Single Married Defacto Divorced
Date of Birth:		Sex:	Male / Female
Surname:		Middle Name:	
First Name:		Preferred Name:	
Nationality:		Are you: (please circle)	Aboriginal TSI Neither
Street Address:			
Postal Address:			
Home Number:		Mobile Number:	
Do you consent to SMS appointment reminders: -			Yes / No
Medicare Number:		Reference No:	Expiry:
DVA Gold/ White No:		Expiry:	Conditions:
Pension Card No:		Expiry:	
Health Care Card No:		Expiry:	
Occupation:			
Next of Kin:	First Name:		
	Surname:		
	Address:		
	Phone No:	(1)	(2)
	Relationship:		
Head of Family: (if child under 16)	Name:	Date of Birth:	Relationship:

How did you hear about us: WOM HealthEngine TV Radio Google Pharmacy

When you Do Not Attend a scheduled appointment- Please note that we charge a **$36.00** DNA fee for any unexplained scheduled appointments, without sufficient notice provided to the practice. This is required to be paid before any more appointments will be made for you.

Reminder Systems: Our Practice provides our patients with preventative care, and early case detection reminders (e.g. immunisations, annual health checks, skin checks and pap smears.

Do you wish to have any relevant health reminders sent to you? Yes No

Privacy

The law gives you certain privacy rights in relation to information that you give to this medical practice. We need your consent to personal information about you. The fact that you have come here implies that you consent to us knowing about your health situation either for a particular event or generally. This form explains what your rights are over the use we make of the information and how we may disclose it to other medical service providers.

The information we may ask you to give us is deeply personal, but not having it will restrict our capacity to provide you with the standard of medical care you expect.

Please carefully read the following information about privacy issues, then sign this form where indicated below. It will go on your file and you may examine it or change it at any time.

The main reason we collect information from you is so we can assess, diagnose and treat your illnesses properly and be pro-active in your health care. We will also use the information you provide in the following ways:

- Administration of this medical practice;
- Billing, including compliance with Medicare and Health Insurance Commission requirements;
- Disclosure to others involved in your health care, including Doctors and Specialists outside of this practice who may become involved in your care. This may occur through referrals to other doctors, or for medical tests and in the reports or results returned to us following the referrals. If necessary, we will discuss this with you.
- Disclosure to others for medical defence purposes if necessary.
- Disclosure to other doctors in this practice, locums and Registrars attached to the practice for the purpose of patient care and teaching. Please let us know if you do not want your records accessed for these purposes, and we will note your record accordingly.
- Disclosure for research and quality assurance activities to improve individual and community health care and practice management. You will be informed when such activities are being conducted and given the opportunity to “opt out” of any involvement.

PATIENTS ACKNOWLEDGEMENT:

I have read this form and understand why collecting information about me is necessary. I am also aware that this practice has a privacy policy on handling patient information.

I understand that I am not obliged to provide any information requested of me. I also understand that failure to provide this medical practice with all the information it needs may restrict the practice’s ability to provide the quality of health care and treatment that I want.

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

I understand that if my information is to be used for any other purposes 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, subject to any limitations on access or disclosure about which I notify this practice now or at any future time.

I acknowledge that I have read this form before signing it, and that a member of staff of this practice has, at my request, clarified any aspects of it that I did not understand.

Patients Name:…….. Date: …….

…….

Signed by Patient OR Guardian of Patient under the age of 16