"keeping Busselton healthy"

NEW PATIENT INFORMATION

Title:	**Birth sex: Male** ☐ **Female** ☐	**Gender identity:**	
First Name:		**Surname:**	
Preferred Name:		**D.O.B:**	
Street Address:			
Suburb:		**Postcode:**	
Postal Address:		**Postcode:**	
Home Phone:		**Work Phone:**	
Mobile Phone:		**Do you consent to SMS reminders?**	**Yes** ☐ **No** ☐
Email:			
Occupation:			
Allergies:	**Nil Known** ☐ **Yes** ☐	**If yes, please describe:**	
Smoking Status:	**Smoker** ☐	**Never Smoker** ☐	**Ex-Smoker** ☐
Ethnicity:		**Do you need an interpreter?**	**Yes** ☐ **No** ☐
Aboriginal or Torres Strait Islander:	**Non-Indigenous** ☐	**Aboriginal** ☐	**Torres Strait Islander** ☐
Medicare Card Number:		**Ref:**	**Expiry:**
DVA Gold Card:	**Yes** ☐ **No** ☐	**Card Number:**	
Health Care Card:	**Yes** ☐ **No** ☐	**Card Number:**	**Expiry:**
Age or Disability Pension:	**Yes** ☐ **No** ☐	**Number:**	**Expiry:**
Sole Parent Pension:	**Yes** ☐ **No** ☐	**Number:**	**Expiry:**
Private Health Insurance:	**Yes** ☐ **No** ☐	**Provider:**	
Next of Kin: (to be different to emergency contact below)		**Phone:**	**Relationship:**
Emergency Contact:		**Phone:**	**Relationship:**

Consent

I provide my consent for The Sunshine Medical Centre & Family Practice to collect, use and disclose my personal information as outlined above. I also similarly provide my consent for the above practice to collect, use and disclose the personal information belonging to my children, who are below the age of consent. I understand that I am entitled to access my own health records except where access would be denied as outlined above. I understand that I may withdraw my consent as to the use and disclosure of my personal information (except when legal obligations must be met).

Patient Name (please print): ______________________________

Patient Signature: ______________________________ **Date:** ______________________________

Parent to sign if patient under the age of 18

Disclaimer: Whilst every effort is made to ensure accuracy, Sunshine Medical Centre & Family Practice does not accept any liability for any injury, loss or damage incurred by use of, or reliance on the information included within this sheet.

PRIVACY ACT 1988

PATIENT CONSENT – TO COLLECT & DISCLOSE INFORMATION

The Privacy Act 1988 requires medical practitioners to obtain consent from their patients to collect, use and disclose that patient's information.

Collection

This means that we collect information that is necessary to properly advise and treat you. Such information may include:

- Full medical history
- Family medical history
- Ethnicity
- Contact details
- Medicare/private health fund details
- Genetic information
- Billing and account details

The information will normally be collected directly from you. There may be occasions when we will need to obtain information from other sources, for example:

- Other medical practitioners, such as GP's and specialists
- Other health care providers, such as physiotherapists, occupational therapists, psychologists, pharmacists, dentists, nurses and
- Hospitals and day surgery units

Both our practice staff and the medical practitioners may participate in the collection of this information.

In emergency situations we may need to collect personal information from relatives or other sources where we are unable to obtain your express prior consent.

Use and Disclosure

With your consent, the practice staff will use and disclose your information for purposes such as:

- Account keeping and billing purposes
- Referral to another medical practitioner or health care provider
- Sending of specimens, such as blood samples or pap smears for analysis
- Referral to a hospital for treatment or advice
- Advice on treatment options
- The management of our practice
- Quality assurance, practice accreditation and complaint hearing
- To meet our obligations of notification to our medical defence organisation or insurers
- To prevent or lessen a serious threat to an individuals' life, health or safety
- Where legally required to do so, such as producing records to court, mandatory reporting of child abuse or the notification of diagnosis of certain communicable diseases.

Access

You are entitled to access your own health records at any time convenient to both yourself and the practice.

Access can be denied where:

- To provide access would create a serious threat to life or health
- There is a legal impediment to access
- The access would unreasonable impact on the privacy of another
- The information relates to anticipated or actual legal proceedings and you would not be entitled to access the information in those proceedings

We ask that, where possible, your request be in writing. We may impose a charge for photocopying or staff time involved in processing your request. Where you dispute the accuracy of the information we have recorded you are entitled to add your version of that information. It is our practice policy that we take all steps to record all of your corrections, and place them with your file but will not erase the original record.