DENMARK MEDICAL CENTRE - NEW PATIENT FORM

Title: ___ Given Name: _____Middle Name: _____Surname:_____

Known as: _____ Date of Birth: ____/____/____ Male / Female

Medicare no: _____ Ref: _____ Expiry: _____

Are you of Aboriginal or Torres Strait Islander origin? ☐ Yes ☐ No

☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal and Torres Strait Islander

Ethnicity _____

Payment Details: Pension Card No: _____Expiry_____

Health Care Card No:_____ Expiry_____

Veteran Card No. (Specific/All)_____Expiry _____

Private Health Fund – Hospital Cover: _____ Basic/Intermediate/Top

Payer: ☐ Self ☐ Other: *Please Specify Name:* _____ *DOB:*_____

*Other Medicare Number:*_____ *Ref:*_____ *Expiry:*_____

Contact Details: Preferred mailing address: Residential or Postal (circle one)

Residential Address: _____

Postal Address: _____

Phone (home) _____ (work) _____ (mobile) _____

Email: _____

Do you give consent for contact on the telephone numbers / addresses you have provided above? This will include* SMS reminders to your mobile phone no. ☐ *Yes* ☐ *No

You may opt out of receiving reminders at any time by advising reception staff or your doctor.

Personal Details:

Marital status: ☐ Single ☐ Married ☐ Defacto ☐ Separated ☐ Divorced ☐ Widowed

Occupation: _____ Country of Birth: _____

Year of Arrival In Aust: _____ Spoken Language:_____

Preferred Language: _____ Interpreter Required ☐

NEXT OF KIN

Name: _____Relationship to you: _____

Phone (home) _____ (work) _____ (mobile) _____

EMERGENCY CONTACT (If different from Next of Kin)

Name: _____Relationship to you: _____

Phone (home) _____ (work) _____ (mobile) _____

Please provide alternative contact details if necessary: _____

Our practice undertakes research, professional development, and quality assurance/improvement activities to improve patient care. All people accessing personal health information for this purpose have signed a written confidentiality agreement.

Our practice uses a reminder system to improve the quality of your health care. The practice sends reminders by mail, SMS or telephone for procedures such as vaccinations, pap tests and other health reviews. If you do not wish to be part of this system please let us know.

I have received a copy of Denmark Medical Centre's current Practice Information sheet. ☐ Yes ☐ No

Signature of patient or guardian _____ Date: _____

Staff to complete ID: Type:……..No: …….. *Initial:* …… Input by

DENMARK Medical Centre

Health Information Collection and Use - Consent Form

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 and/or SMS's 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 practice before I sign.	☐

Patient's name: …… **Date:** ……..

Patient's signature: ……

Signed as Guardian for child: …… **Name:** (printed) ……

Please hand this form to the receptionist when completed

Unit 3 , 3 Mount Shadforth Rd Denmark WA 6333
Phone: 08 9848 4111 Fax: 08 9848 2192
Email: admin@denmarkmedicalcentre.com.au