Waterhall Medical Centre

TITLE: Mr Mrs Miss Ms Mst Other (please specify): _____

Gender Identity (Circle one): Male/Female/Transgender/Non-Binary/Gender Diverse/Different Identity

First Name (as shown on Medicare Card): _____

Surname (as shown on Medicare Card): _____

Date of Birth: _____

Address: _____

Suburb: _____ Post Code: _____

Home Phone: _____ Mobile: _____ Work: _____

Email Address: _____

Preferred method of contact (Circle One): Email / SMS

Occupation: _____

****PLEASE COMPLETE – ENSURES YOU RECEIVE CARE SPECIFIC TO YOUR ETHNICITY NEEDS**
Are you of Aboriginal or Torres Strait Island Descent (Circle One): Yes / No
If so, are you registered with Closing the Gap? Yes / No

Do you require a translator? (Circle One): Yes / No

What is your country of birth? _____

Medicare No: __ __ __ __ __ __ __ __ __ __ Position no: ____ Expiry Date: _____

****IMPORTANT ARE YOU REGISTERED THROUGH MY MEDICARE WITH YOUR PREVIOUS PRACTICE?**

(please check your MyGov Medicare as you will need to deregister from your previous clinic to attend this practice)
Please tick if you have deregistered or if you were never registered elsewhere. ☐

Healthcare/Pension Card No (Please circle): _____ Expiry Date: _____

DVA Card No: _____ Colour: _____ Condition/s Covered_____

Private Health Fund Name: _____ Number: _____

Tick this box if you do NOT want your records uploaded to My Health Record ❑
(uploads include allergies, medications, immunisations & medical condition ONLY. Uploads DO NOT INCLUDE doctor's notes) This information is important for hospital and emergency situations across all of Australia.

Next of Kin: _____ Contact No: _____

Relationship: _____

Emergency Contact: _____ Contact No: _____

Relationship: _____

IT IS THE PATIENT'S RESPONSIBILITY TO FOLLOW UP ON RESULTS

Waterhall Medical Centre

This general practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose and treat illnesses and medical conditions, ensuring we are proactive in your health care. To enable ongoing care, and in keeping with the *Privacy Act 1988* and *Australian Privacy Principles*, we wish to provide you with sufficient information on how your personal information may be used or disclosed; we will record your consent or restrictions to this consent.

Your personal information will only be used for the purposes for which it was collected or as otherwise permitted by law, and we respect your right to determine how your information is used or disclosed.

The information we collect may be collected by a number of different methods, and may include, but not limited to: medical test results, notes from consultations, Medicare details, data collected from observations and conversations with you, and details obtained from other health care providers (e.g. specialist correspondence).

By signing below, you (as a patient/parent/guardian) are consenting to the collection of your personal information, and that it may be used or disclosed by the practice for the following purposes:

- Administrative purposes in the operation of our general practice.
- Billing purposes, including compliance with Medicare requirements.
- Follow-up reminder/recall notices for treatment and preventative healthcare, frequently issued by SMS.
- Disclosure to others involved in your health care, including treating doctors 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 the referrals.
- Accreditation and quality assurance activities to improve individual and community health care and practice management.
- For legal related disclosure as required by a court of law.
- For the purposes of research only where de-identified information is used.
- To allow medical students and staff to participate in medical training/teaching using only de-identified information.
- To comply with any legislative or regulatory requirements, e.g. notifiable diseases.
- For use when seeking treatment by other doctors in this practice.

At all times we are required to ensure your details are treated with the utmost confidentiality. Your records are very important and we will take all steps necessary to ensure they remain confidential.

Please complete the form below if you understand and agree to the following statements in relation to our use, collection, privacy and disclosure of your patient information.

CONSENT

I have read the information above and understand the reasons why my information must be collected, and the purposes for which my information may be used or disclosed. I understand that if my information is to be used for any purpose other than that set out above, my further consent will be obtained.

I give permission for my personal information to be collected, used and disclosed as described above, including contact via SMS to my mobile phone number and/or my email address. I understand that only my relevant personal information will be provided to allow the above actions to be undertaken and I am free to withdraw, alter or restrict my consent at any time by notifying this practice in writing.

Patient name: (please print) _____

Signature: _____Date: _____

If not patient signing - your name (please print) _____

IT IS THE PATIENT'S RESPONSIBILITY TO FOLLOW UP ON RESULTS