Carrier Street Clinic

New Patient Information Form

Title (please circle) Dr / Mr / Mrs / Ms / Miss / Mstr / Rev / Sr

Birth Sex - Male/Female, **Gender Identity** _____**Preferred Pronouns** _____

First Name: _____ **Surname**: _____

Preferred Name: _____ **DOB**: _____

Street Address: _____

_____

Town/Suburb: _____ **Postcode**: _____

Postal Address (if different from above)

PO Box/Street: _____

Town/Suburb: _____ **Postcode**: _____

Mobile No: _____ **Home Ph. No:** _____

Work Ph. No: _____

Email Address: _____

Occupation: _____

Are there any Legal/Guardianship Obligations concerning healthcare for this patient, including Medical Power of Attorney?
YES/NO – if yes please provide documents

Country of Birth - _____

In order to assist us with health initiatives and tailor care, do you identify as -

□ **Aboriginal** □ **Torres Strait Islander** □ **Aboriginal & Torres Strait Islander**

□ **Other** _____ □ **Prefer not to disclose**

Do you authorise the practice to send you SMS appointment confirmations? YES / NO

Our practice provides our patients with preventive care and early case detection reminders

Do you consent to have any relevant reminders sent to you?

□ Yes **– via mail** ***OR*** □ **Yes – SMS** □ **No**

Please present to Staff if relevant:

Medicare Card **Health Care** Card **Pension** Card **DVA**

WorkCover Details – Please provide written proof of claim from Insurance Company (including start date of claim and claim number)

Next of Kin

First Name: _____ **Surname**: _____

Phone No. _____ **Relationship**: _____

Emergency Contact

First Name: _____ **Surname**: _____

Phone No. _____ **Relationship**: _____

Agreement -

- **I acknowledge I will be expected to pay my account on the day of consultation, if the account is not settled, no future appointments will be booked, until such time the debt is cleared.**
- **Moving forward, I will continue with a good payment habit.**
- **Please note that there are extra consumable fees for procedures performed, also payable on the day of consultation.**
- **I knowledge that I will attend my scheduled appointments, or inform the clinic in a timely manner if I cannot.**
- **If I miss 2 consecutive appointments I understand I will no longer be a patient of Carrier Street Clinic**

☐ Yes ☐ No

Signature - _____

Date - _____

Your Health Information

To enable ongoing care and total quality improvement within this practice and in keeping with the Privacy Act (1988) and the National Privacy Principles, we wish to provide you with sufficient information on how your personal health information may be used or disclosed and record your consent or restrictions to this consent.

Your personal health 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 personal health information is used or disclosed. The information we collected may be collected by a number of different methods and examples may include: medical test results, notes form consultations, Medicare and health insurance details, data collected from observations and conversations with you, and details obtained from other health care providers (eg. specialist correspondence).

By signing below, you (as a patient/guardian) are consenting, that on obtaining your personal health information it may be used or disclosed by the practice for the following purposes:

- follow up reminder/recall notices for treatment and preventive healthcare;
- for accounting procedures and the collection of professional fees;
- the diagnosis and treatment of any health condition, including the communication of relevant information only, to practice staff, specialists and other healthcare providers to ensure quality care is provided;
- for Accreditation and Quality Assurance activities which are conducted by professionally trained non-treating GPs and other professionally trained and qualified persons, eg. General Practice Managers;
- for legal related disclosures, as required by Court of Law;
- for the purposes of research where de-identified information is used;
- to allow medical students and staff to participate in medical training/teaching using only de-identified information;
- for disease notification, as required by law;
- 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.

I, _____, give my permission for my personal health information to be collected, used and disclosed above. I understand only my relevant personal health information will be provided to allow the above actions to be undertaken and I am free to withdraw my consent at any time by notifying this practice in writing.

Patient (please print): _____

Signature: _____

Date: _____

If not the Patient signing – Your name (please print): _____

DATE _____

Previous General Practice Details –

To whom it may concern,

Re:

Patient Name _____

DOB _____

Address _____

This patient has expressed a desire to attend this practice. To assist towards this patients continuity of medical care, could you please forward a copy of their previous medical history for our files? Could this be sent in electronic form, by e-mail to cscadmin@carrierstreetclinic.com.au?

If you are a Medical Director/Best Practice user, please export the file in XML format. All other programs please send file in PDF format on CD.

Many thanks,

Signed on behalf of Carrier Street Clinic

I _____hereby request and authorise the release of medical history to Carrier Street Clinic.

Patient Signature _____ DATE _____

Parent/Guardian Signature _____ DATE _____