

Waverley Family Healthcare
58 Pinewood Drive
Mount Waverley, 3149 Vic

New Patient Form

This complete medical history is important for you to obtain good health care. **Please feel free to discuss with the doctor if you are unsure of anything or cannot write it down.** As you are providing us with health information please also read and sign a consent form to allow us to collect and use your health information.

Personal Details

Title : Mr / Mrs / Miss / Ms _____ First Name: _____

Surname : _____ Date of Birth: ____/____/____

Gender : Male / Female / Intersex / Others

Medicare no.: _____ Ref : _____ Expiry Date : _____

Aboriginal/Torres Strait Islander: Yes/No Ethnicity: _____

Country of birth: _____

Address: _____

Suburb: _____ Postcode : _____

Mobile : _____ Home phone Number _____

Work: _____ Email: _____

Pension no.: _____ HCC Expiry: _/ _/ _

Healthcare Card/ DVA /Concession /Pensioner : _____ HCC Expiry: _/ _/ _

Marital Status (circle): Single, Married, Engaged, Divorced, de facto, have a partner, widowed, others: _____

Emergency Contact Name : _____ Emergency Contact No : _____
Emergency Contact Relationship : _____

Next of Kin Contact Name : _____ Next of Kin Contact No. : _____
Next of Kin Relationship : _____

Any Religious Affiliation: _____ Occupation: _____

Previous Doctor : _____

Previous Clinic Name : _____

Address: _____

Other family members attending this practice: _____

Preferred language: _____ Any special needs: _____

Any custody issues: _____

Name : _____

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 through 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 eg notifiable diseases.
- For reminder letters 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 medical practice before I sign.

Patients Name _____ Date ____ / ____ / ____

Patient's signature _____

Signed as Guardian for child _____ Name (printed) _____

