MANDURAH DOCTORS
UNIT 6, 5 MURDOCH DRIVE
GREENFIELDS WA 6210
Phone: 9535 8700 Fax: 9535 8733

New Patient Information Form

Title			
Family Name	**Given Name**	**Middle Name**	**Preferred Name**
Date of birth	**Sex**	**Occupation**	
Allergies	**Reaction**	**Regular Medication**	
Are you of Aboriginal or Torres Strait Island decent? ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ No		**Country of Birth**	

Home Address Street number and name:	**Postal Address**
City/Suburb:	City/Suburb:
State:	State:
Postcode:	Postcode:

Home Phone	**Mobile Number**	**Work Phone**
E-mail address		

Do you consent to SMS reminders Yes/No	**Do you consent to receive electronic clinical communication:** Yes/No

Medicare Number	☐ **Pension Concession Card** ☐ Health Care Card ☐ Commonwealth Senior Card	**DVA Card Details**	**Private Health Insurance Fund**
Ref No.:	No.:	No.:	No.:
Expiry:	Expiry:	Expiry:	Expiry:

Do you consent for our GPs and practice staff to access and use your personal information so they can provide you with the best possible health care? Yes/No

COLLECTION STATEMENT: Our practice will need your personal information to provide healthcare services for you. Our main purpose for collecting, using and sharing your personal information is to manage your health. We also use it for directly related business activities, such as financial claims and payments, practice audits and accreditation, and business processes (eg. staff training).

Next of Kin Title:	**Emergency Contact** Title:
First Name:	First Name:
Surname:	Surname:
Address:	Address:
City/Suburb:	City/Suburb:
Postcode:	Postcode:
Phone Contact	Phone Contact:
Alternate Contact:	Alternate Contact:
Relationship:	Relationship:

Smoking History	**Alcohol intake**	**Medical History SELF**	**Family Medical History**
☐ Non smoker	☐ Non drinker		
☐ Ex smoker	☐ Ex drinker		
Year started:	Year started:		
Year stopped:	Year stopped:		
☐ Smoker	☐ Drinker		
How many per day?	No. of drinks per day?		

Signature:	**Date:**

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Welcome to Mandurah Doctors

To enable ongoing care and total quality improvement within this practice, and in keeping with the Privacy Act 1988 and 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 collect may be collected by a number of different methods and examples may include: medical test results, notes from consultations, Medicare and health insurance 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/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.
- Accreditation and Quality Assurance activities are conducted by professionally trained non-treating GP's and other professionally trained and qualified persons eg. General Practice Managers.
- 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.
- For disease notification as required by law.
- For use when seeking treatment by other doctors in this practice.
- To be placed on national registers (e.g. immunisation data) or state and territory based systems (e.g. cervical screening - pap smears or familial cancer registries).

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/my child's/the person I care for (please circle) personal health information to be collected, used and disclosed as described above. I understand only relevant personal health 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.

Signature: _____ Date:_____