MILDURA FAMILY MEDICAL CENTRE

New Patient Form

General Information

Title: _____ **Preferred Pronouns:** _____

Surname: _____

First Name: _____

Preferred Name: _____

Date of Birth: _____ **Birth Sex:** _____ **Gender Identity:** _____

Home Address: _____

Suburb: _____ **State:** _____ **Postcode:** _____

Postal Address: _____

Suburb: _____ **State:** _____ **Postcode:** _____

Mobile Phone: _____ **Home Phone:** _____

Work Phone: _____ **Email:** _____

Do you consent to receiving your Health Reminders via SMS? ☐ Yes ☐ No

Emergency Contact Details

Name: _____ **Relationship:** _____

Contact Phone: _____

Next of Kin

Name: _____ **Relationship:** _____

Contact Phone: _____ _____

Healthcare Identifier Numbers

Medicare: _____ **Ref:** ____ **Expiry:** _____

Concession: _____ **Expiry:** _____

Concession Type: ☐ **Pension** ☐ **Healthcare Card** ☐ **Commonwealth Seniors Card**

Dept Vet Affairs File Number: (if applicable: _____ ☐ **Gold** ☐ **White**

Cultural Identity

Country of birth: _____

To assist with health initiatives, do you identify as Aboriginal and/or Torres Strait Islander?

☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, Aboriginal and Torres Strait Islander

Are you registered for the Closing the Gap program? ☐ Yes ☐ No

Do you identify as someone from a culturally, and/or linguistically diverse background? ☐ Yes ☐ No

Do you require a translator? ☐ Yes ☐ No If yes, please list language spoken: _____

142 Pine Avenue
Mildura VIC 3500

T: 03) 5002 9290
F: 03) 5002 9293

mildurafamilymc.com.au
E: reception@mildurafamilymc.com.au

New Patient 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 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. ☐

If you are unsure and would like to discuss this further with someone from the medical practice before you sign, please see reception.

Patient Name: _____

Patient Signature: _____ **Date:** _____

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