HALY HEALTH & SKIN MEDICAL CENTRE

New Patient Information Sheet

Title:_____First Name:_____Middle Name:_____
Surname:_____Known as (if different to above):_____Date of Birth:_____

Are you Aboriginal/Torres St Islander or another Cultural Background? Yes/No/Both/Other_____
Ethnicity: _____Main Language spoken at Home:_____

Medicare Number:___ ___ ___ ___ ___ ___ ___ ___ ___ ___
Expiry Date:___ ___/___ ___
Reference No:___ **(Please note this is the number directly to the Left of your name printed on your Medicare Card)**

Pension/Health Care Card (Please state which) _____Number on card __ __ __ __ __ __ __ __ __ __
Pension/Health Care Card Expiry Date __/__/__

Do you have Private Health Insurance Yes/No - Name of Private Health Insurance Fund _____

Your Current Residential Address:_____
Your Postal Address:_____Home Phone:_____
Mobile Phone:_____Work Phone:_____Email:_____

Next of Kin (Emergency Contact):_____Relationship_____
Home Phone Number_____Mobile Phone Number_____

(A second contact - different to your Next of Kin contact is required)
Name:_____
Relationship_____Phone:_____

<u>Your Personal Information</u>
Marital Status:_____Occupation_____Country of Birth_____
Religion/Culture:_____

Do you consent to your Results or Appointments being discussed with other members of your family? Eg spouse.
If so whom are we permitted to discuss this with?_____

Where did you hear about us? Word of Mouth/Radio/Website/Facebook/Other _____

Are you interested in a complimentary skin health consultation? Yes/No

Do you consent to receiving relevant Health information via SMS? Yes/No - Via Email? Yes/No
I am aware of the risks associated with engaging in electronic communication. I understand Email transmission cannot be guaranteed to be secure. Yes/No

Do You Have any Allergies?_____
Who is you usual GP?_____

Privacy Laws: I hereby give my consent for Haly Health & Skin Medical Centre to obtain/request medical information that may be necessary for the management of any medical condition that may arise. Your medical record is a confidential document. It is the policy of this practice to maintain security of personal health information at all times and to ensure that this information is only available to authorised members of the staff.

Signed:_____Date:_____

Office Use Only Photo Identification Viewed Yes / No Viewed by Staff Member_____

Health Information Collection and Use Consent Form

Haly Health & Skin Medical Centre

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.	☐
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.	☐

Patient's name: ……
Patient's signature: ……
Signed as Guardian for child: ……...
Name: (printed) ……..……..…
Date :: ……..….

Office Use Only Photo Identification Viewed Yes / No Viewed by Staff Member_____