

New Patient Form

As part of our commitment to providing you with the best care possible, it is important for your health record to be kept as up to date as possible. Please assist us by completing the following.

Title	<input type="checkbox"/> Mr	<input type="checkbox"/> Mrs	<input type="checkbox"/> Ms	<input type="checkbox"/> Miss	<input type="checkbox"/> Master	<input type="checkbox"/> Dr
Sex	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Transgender	Medicare Gender: M / F		
Marital Status	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Widowed	<input type="checkbox"/> Divorced	<input type="checkbox"/> Defacto	<input type="checkbox"/> Separated
Given Names						
Surname						
Date of Birth	__ / __ / ____					
Medicare Number	_____ Ref __ Expiry Date __ / ____					
Health Initiatives (Please Tick)	Aboriginal <input type="checkbox"/>					
	Torres Straight Islander <input type="checkbox"/>					
DVA Gold/White	Both Aboriginal & Torres Straight Islander <input type="checkbox"/>					
	Neither: <input type="checkbox"/>					
Government Card Number Healthcare <input type="checkbox"/> Pension <input type="checkbox"/>				Expiry Date		
Private Health Details						
Street Address						
Suburb and Postcode				Postcode		
Phone	Home:		Mobile:		Work:	
Email						
Occupation						
Country of Birth				Year of arrival in Australia (if applicable)		
Spoken Language	Interpreter required: Yes / No					
Next of Kin Details	Name:		Relationship:		Phone:	
Emergency Contact Details <input type="checkbox"/> Same as Next of Kin	Name:		Relationship:		Phone:	
Allergies						

Wishart Medical Centre
590 Mount Gravatt-Capalaba Road
Wishart Qld 4122

Type of Care	<input type="radio"/> Once off Visit (has regular GP) <input type="radio"/> Continuing (moving from another practice) <input type="radio"/> Overseas Visitor <input type="radio"/> Not Sure
How did you hear about the Clinic?	<input type="radio"/> Another Doctor <input type="radio"/> Local Advertising <input type="radio"/> Web/internet <input type="radio"/> Word of mouth <input type="radio"/> Other _____

Patient Background	Australia is a genuinely multicultural society. To tailor appropriate care, encourage understanding and appreciation between people from different nationalities and backgrounds.	
	Do you identify as someone from a culturally and/or linguistic diverse background?	<input type="checkbox"/> No
		<input type="checkbox"/> Yes. Please Elaborate:

Privacy Consent Form

We require your consent to collect personal information about you. Please read this information carefully and sign where indicated below.

This medical practice collects information from you for the primary purpose of providing quality health care. 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. This means we will use the information you provide in the following ways,

- Administrative purposes in running our medical practice
- Follow up reminder/recall notices for treatment and preventive healthcare by email and/or sms
- For legal related disclosure as required by a court of law.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your health care, 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 the referrals.

- Disclosure to other doctors in the practice, locums and by Registrars attached to the practice for the purpose of patient care and teaching.
- I give permission for my general practice to obtain medical information from other health professionals if necessary

If you have any questions in relation to any of the above matters please raise these with your doctor

- ✓ I have read the information above and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling patient information.
- ✓ I understand that I am not obligated to provide any information requested of me, but that my failure to do so might compromise the quality of health care and treatment given to me.
- ✓ I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand 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 above, my further consent will be obtained.
- ✓ I consent to the handling of my information by Wishart Medical Centre for the purposes set above, subject to any limitations on access or disclosure that I have given notification of

Print Name: _____ Signed: _____

Date: ____/____/____