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

Better Health Medical Centre
55 Creek Road
Mount Gravatt Qld 4122

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	☐ Mr	☐ Mrs	☐ Ms	☐ Miss	☐ Master	☐ Dr
Sex	☐ Male	☐ Female	☐ Transgender		Medicare Gender: M / F	
Marital Status	☐ Single	☐ Married	☐ Widowed	☐ Divorced	☐ Defacto	☐ Separated
Given Names						
Surname						
Date of Birth	__ __ / __ __ / __ __ __ __					
Medicare Number	__ __ __ __ __ __ __ __ __ __ Ref __ Expiry Date __ __ / __ __ __ __					
Health Initiatives (Please Tick)	Aboriginal ☐ Torres Straight Islander ☐ Both Aboriginal & Torres Straight Islander ☐ Neither: ☐					
DVA Gold/White			Expiry Date			
Government Card Number Healthcare ☐ Pension ☐			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 ☐ Same as Next of Kin	Name:	Relationship:	Phone:			
Allergies						

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Type of Care	○ Once off Visit (has regular GP) ○ Continuing (moving from another practice) ○ Overseas Visitor ○ Not Sure
How did you hear about the Clinic?	○ Another Doctor ○ Local Advertising ○ Web/internet ○ Word of mouth ○ 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?	☐ No
		☐ 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 you 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 you 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 you 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/Better Health 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: _____/_____/_____