Mindarie Keys Medical Centre

NEW PATIENT DETAILS

To ensure accurate and up to date information is entered on our system, please complete the following form in full. This information is only to be used by our clinical staff and will not be divulged to a third party without your written consent.

Please Circle: Mr Mrs Ms Master Miss

Surname: _____

Given Name/s: _____

Date of Birth: _____/_____/_____ Please Circle: Male / Female

Address: _____

Suburb: _____ **Postcode:** _____

Home Telephone: _____ **Work Telephone**: _____

Mobile: _____**Email Address:** _____

Next of Kin: _____ **Telephone Number**:_____

Relationship to Next of Kin: _____

Emergency Contact: _____ **Telephone Number:** _____

Relationship to Emergency Contact:_____

Please tick if applicable: Aboriginal: ☐ Torres Strait Islander: ☐

Other Ethnicity: _____ **Language spoken:** _____ **Interpreter required**:☐

CANCELLATION POLICY

Please be aware that we require 2 hours' notice of appointment cancellations. Failure to cancel an appointment with less than 2 less hours' notice will result in a fee of $25 being charged. Payment will be required before your next doctor's appointment.

Signed: _____ Date: _____

OFFICE USE ONLY

Medicare: _____ REF: _____ Expiry: _____

Please Circle: HCC Pensioner Commonwealth Seniors DVA White DVA Gold

Entitlement Number: _____ Expiry: _____

Mindarie Keys Medical Centre

PRIVACY STATEMENT – CONSENT FORM

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 healthcare needs.

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

We will use the information you provide in the following ways:

- Administrative purposes in running our medical practice
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirement
- 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. Please let us know if you do not want your records accessed for these purposes, and will note your record accordingly.
- Disclosure for research and quality assurance activities to improve individual and community health care and practice management. You will be informed when such activities are being conducted and given the opportunity to 'opt out' of any involvement.

I have read the adjacent information 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 obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the healthcare 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 purposes other than those outlined at left, my further consent will be obtained.

I consent to the handling of my information by this practice for the purposes outlined at left, subject to any limitations on access or disclosure of which I notify this practice.

Name: (please print) _____

Signature: _____

Date: _____