Easy Street Medical Centre- New Patient Consent Form **Date:** _____

Title:____ Surname:_____ First Name:_____ Middle Name:_____

Date of Birth: _____

Ethnicity: Australian ___ Aboriginal ___ Torres Strait Islander____

Aboriginal/Torres Strait Islander____ Other: _____

Address: _____

Home Ph: _____ **Mobile:** _____ Work Ph: _____

Email: _____

Occupation: _____

Medicare Care Number*:* _____ Ref No: _____ Exp Date: _____

Concession Card *(Health Care Card/ Pension card):* Card No: _____

Expiry Date: _____

DVA Number: _____ Gold/White Specific

Next of Kin: _____ Relationship: _____ Ph: _____

Emergency Contact: _____ Relationship: _____Ph: _____

Health Questionnaire:

Allergies: _____*Reaction:* _____

Please List HEALTH PROBLEMS (eg asthma, diabetes, high blood pressure, high cholesterol etc) and OPERATIONS/PROCEEDURES (eg appendicectomy, colonoscopy, mole removal etc):

_____

Please list any MEDICATIONS that you are using regularly or occasionally:

Please list any FAMILY HISTORY of health problems (eg heart disease, kidney disease, bowel cancer):

Do you SMOKE? Never Ex-smoker, when did you quit? _____

Yes, how many on an average day? _____Year commenced_____

Do you DRINK ALCHOHOL? Never _____Yes how often & how much? _____

Have you ever had a PAP SMEAR (if applicable)?

Never Yes, when was your last smear? _____ Any abnormalities? _____

Please turn over to complete & read/ sign the Patient Consent Form. Thank You

Health Information Collection and Use Consent Form

Do you consent to contact by the Practice for routine Reminders/ Recalls? *YES* *NO*

How did you hear about us? Referral from a friend or family member White Pages

Flyer/ Local Paper Online Search Other Please specify _____

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 & Health Insurance Commission Req
- Disclosure to others involved in your healthcare including treating doctors & specialists outside this medical practice, as well as Doctors, Locums inside the Practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following referrals.
- For research and quality assurance activities to improve individual and community health care and practice management.
  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 management.

I have read the information above and understand the reasons why my information must be collected. ☐

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 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 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. ☐

I consent to my Health Summary being uploaded for *My Health Record* ☐

Patient Name……. Date…….

Patients Signature…….

Signed as Guardian for child:…….Name (printed) ……..