STATION SQUARE MEDICAL CENTRE

New Patient Form

Title ☐ Mr ☐ Dr ☐ Mrs ☐ Ms ☐ Miss ☐ Master

Given Name(s) _____ Surname _____

Preferred Name _____ Date of Birth ___ ___ / ___ ___ / ___ ___ Gender _____

Street Address _____ Suburb _____

Postcode _____ Email _____

Home phone _____ Work phone _____ Mobile _____

ATSI Status ☐ Aboriginal ☐ Torres Strait Islander
☐ Aboriginal & Torres Strait Islander ☐ Non-Aboriginal & Torres Strait Islander

Cultural Background _____ Occupation _____

Medicare No. ____ ____ ____ ____ ____ ____ ____ ____ ____-____ Ref. No. _____ Exp. Date ___ ___ /___ ___

DVA ☐ Gold ☐ White – Number _____ Exp. Date ____ ____ / ____ ____

Pension Card Number _____ Exp. Date ____ ____ / ____ ____

Health Care Card Number _____ Exp. Date ____ ____ / ____ ____

Next of Kin Name _____ Phone _____

Relationship to Patient _____

Emergency Contact Name _____ Phone _____

Relationship to Patient _____

Do you smoke cigarettes? ☐ Yes ☐ No If yes, how many cigarettes per day/week? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how many glasses per day/week/month? _____

Allergies _____

Current Medications _____

***How did you find out about us? _____

Signature _____ Date _____ _____ / _____ _____ / _____ _____

Station Square Medical Centre is a mixed billing practice. We bulk-bill Pensioners, HCC holders & children under 16. For private accounts we accept cash, credit card and Eftpos and we can process your Medicare rebate for you electronically. For our current fee structure, visit www.stationsquaremc.com.au/fees or see notice on our Reception desk.

Reminder System: Our practice is committed to preventative care. We seek your permission to be included on our reminder system. We may issue you with a reminder notice offering you preventative health services appropriate to your care. If you do not wish to be part of this system please advise one of our team members.

Privacy: Your personal information is kept secure with access to Doctors and staff necessary within our practice. Your personal information is only disclosed to a third party where you could reasonably expect such disclosure. i.e. Specialist Referral. To see our Privacy Policy, visit our website or ask one of our Receptionists to view it.

Health Information Collection and Use Consent Form

Station Square Medical Centre, Ground Level, 1-3 Burlington Street, Oakleigh 3166 Phone: 9568 1700 Fax: 9568 8344

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 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.

IF YOU ARE UNSURE, PLEASE DISCUSS FURTHER WITH YOUR DOCTOR BEFORE SIGNING

Patient name: (please print) _____

Signature: _____ Date:_____

If not patient signing - your name (please print) _____

Your relationship to patient (e.g. Mother, Father, guardian) _____

(December 2020)