GOLD COAST GP superclinic

Gold Coast GP Super Clinic New Patient Information Forms

We are committed to providing our patients with the best care. To do this it is essential that your health record is kept up to date and accurate.

Please assist us by completing the following:

Title (please circle)	**Master Mr Mrs Ms Miss**	
First Name		
Surname		
Date of Birth		
Street Address **Suburb and Post Code**		
Home Phone		
Work Phone		
Mobile Phone		
Email Address		
Next of Kin	**NAME:**	
	PHONE:	**RELATIONSHIP:**
EMERGENCY CONTACT (Name and Telephone number of the person we can contact if needed – not living with you)	**NAME:**	
	PHONE:	**RELATIONSHIP:**

Please advise us of your COUNTRY OF BIRTH and cultural heritage to help us address your health care needs: ______________________

To assist with health initiatives - are you Aboriginal or Torres Strait Islander?

☐ Yes - Aboriginal ☐ Yes - Torres Strait Islander ☐ Yes - Aboriginal & Torres Strait Islander ☐ No

Reminder Systems:

As part of our services we will send appointment reminders via SMS to ensure our patients make their appointments. Our practice also offers to provide our patients with preventive care and early case detection reminders, for example: immunisations, annual health checks, skin checks and pap smears.

☐ *Please tick this box if you do not wish to receive preventive care reminders.*

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WRITTEN PATIENT CONSENT

Welcome to the Gold Coast GP Super Clinic.

To enable ongoing care and total quality improvement within this practice, and in keeping with the Privacy Act 1988 and National Privacy Principles, we wish to provide you with sufficient information on how your personal health information may be used or disclosed and record your consent or restrictions to this consent.

Your personal health information will only be used for the purposes for which it was collected or as otherwise permitted by law and we respect your right to determine how your personal health information us used or disclosed.

The information we collect may be collected by a number of different methods and examples may include: medical test results. Notes from consultations, Medicare and health insurance details, data collected from observations and conversations with you, and details obtained from other health care providers (e.g. specialist correspondence).

By signing below, you (as a patient/guardian) are consenting, that on obtaining your personal health information it may be used or disclosed by the practice for the following purposes:

- Follow up reminder/recall notices for treatment and preventive healthcare.
- For accounting procedures and the collection of professional fees.
- The diagnosis and treatment of any health condition, including the communication of relevant information only, to practice staff, specialists and other healthcare providers to ensure quality care is provided.
- Accreditation and Quality Assurance activities are conducted by professionally trained non-treating GP's and other professionally trained and qualified persons eg. General Practice Managers.
- For legal related disclosure as required by a court of law.
- For the purposes of research only where de identified information is used.
- To allow medical students and staff to participate in medical training/teaching using only de identified information.
- For disease notification as required by law.
- For use when seeking treatment by other doctors in this practice.

At all times, we are required to ensure your details are treated with the utmost confidentiality. Your records are very important and we will take all steps necessary to ensure they remain confidential.

I give my permission for my personal health information to be collected, used and disclosed as described above. I understand only my relevant personal health information will be provided to allow the above actions to be undertaken and I am free to withdraw, alter or restrict my consent at any time by notifying this practice in writing.

Patient Name: (Please Print) _

Signature: _ Date: _

If not Patient signing

Your Name: (Please Print) _

Signature: _ Date: _

Your relationship to Patient (e.g. Mother, Father, Guardian): _

Thank you.

Type of Card	Number		Date of Expiry	
Medicare		IRN:		
Pension/Health Care				
DVA			Colour:	

(Reception will fill this out – please bring your cards and this completed form to front desk.)