# New Patient Information Form

We are committed to providing our patients with the best care. To do this, it is essential that your health record contains complete and accurate information. Please assist us by completing your new patient record form:

| **Contact Information** | | | |
|---|---|---|---|
| Gender: | ☐ Female | ☐ Male | ☐ Non-Binary |
| Pronouns: | ☐ She/Her/Hers | ☐ He/Him/His | ☐ They/Them/Their |
| Gender at birth: | | | |
| Title: | | | |
| Surname: | | | |
| First Name: | | | |
| Date of Birth: | | | |
| Street Address: | | | |
| Postal Address: *(if different to above)* | | | |
| Home Phone: | | | |
| Work Phone: | | | |
| Mobile Phone: | | | |
| Email: | | | |

| **Emergency Contact Details** | |
|---|---|
| Name: | Relationship to you: |
| Home Phone: | |
| Mobile Phone: | |

| **Next of Kin** | |
|---|---|
| Name: | Relationship to you: |
| Home Phone: | |
| Mobile Phone: | |

**Healthcare Identifiers**

Medicare Number: _____ Ref: _____ Expiry: ___/_____

Dept. of Veterans' Affairs File Number: _____ ☐ Gold

☐ White *Condition:_____

Concession (Pension/Health Care) Card Number: _____ Expiry: ___/_____

**Cultural Identity**

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

☐ No ☐ Yes – Aboriginal ☐ Yes - Torres Strait Islander ☐ Yes - Aboriginal and Torres Strait Islander

Australia is a multicultural society. To provide better care and foster understanding, do you identify with a particular ethnicity or language background?

☐ No

☐ Yes - Please elaborate _____

*If yes, do you require an interpreter service?* ☐ No ☐ Yes

# New Patient Information Form

*Patient Consent*

**Please read this consent form carefully before signing.**

This general practice collects information to provide high-quality healthcare. To properly assess, diagnose, and treat illnesses, we require your personal details and full medical history.

We adhere to the *Privacy Act 1988* and the *Australian Privacy Principles (APPs)* and aim to keep you informed about how your information may be used or disclosed.

Your personal information will be used for purposes including:

- Administrative and billing purposes, including Medicare compliance.
- Follow-up reminders and recall notices via SMS.
- Disclosure to other healthcare providers involved in your care.
- Accreditation and quality assurance activities.
- Legal disclosures as required by law.
- Research using de-identified information.
- Medical training for students and staff, using de-identified information.
- Compliance with legislative or regulatory requirements.
- Use of Artificial Intelligence (AI) for administrative and clinical tasks, including appointment scheduling, reminders, billing, and diagnostic assistance. AI use aligns with our Privacy Policy, ensuring confidentiality and security.

We take all reasonable steps to ensure your information is treated confidentially and securely.

By signing below, you consent to the collection, use, and disclosure of your personal information as described. You also acknowledge that the practice uses AI to assist with administrative and clinical tasks and understand how your information is safeguarded.

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**I, _____, have read and understand the above information regarding the collection and use of my personal information. I give permission for my personal information to be collected, used, and disclosed, including contact via SMS to my mobile phone.**

**Patient Name**: (please print) _____

**Signature**: _____ Date: _____

If not the patient signing:
**Your Name**: (please print) _____
**Your Relationship to Patient**: (e.g., Mother, Father, Guardian) _____

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*Practice Use Only*

**Witnessed by**: (staff signature) _____