NEW PATIENT FORM

(Please fill out all applicable information below)

TITLE : _____ **FIRST NAME :** _____ **MIDDLE INITIAL :** _____

SURNAME : _____ **PREFERRED NAME:** _____

DATE of BIRTH : ____/____/____ **Gender:** ☐ **Male** ☐ **Female** ☐ **Intersex** ☐ **Transgender**

If born in Australia, are you of ABORIGINAL or Torres Strait Islander origin? ☐ **NO** / ☐ **YES**

ETHNICITY: _____

HOME ADDRESS: _____

SUBURB: _____ **POSTCODE:** _____

HOME NUMBER: _____ **MOBILE NUMBER :** _____

WORK NUMBER: _____ **EMAIL :** _____

POSTAL ADDRESS: if different from above: _____

MARITAL STATUS : ☐ **Single** ☐ **Married** ☐ **De facto** ☐ **Separated** ☐ **Divorced** ☐ **Widowed**

OCCUPATION : _____

COUNTRY OF BIRTH: _____ **PRIMARY LANGUAGE :** _____

MEDICARE CARD NUMBER:

REFERENCE NO
(Number next to your name)

EXPIRY DATE: /

Administration use only.
Medicare card has been sighted

Administration signature: _____

DVA PATIENTS: Card Number: _____ ☐Gold ☐ White

NEXT OF KIN DETAILS (FOR PATIENT)

Relative's Name: _____ **Phone:** _____

Relationship to Patient: _____

EMERGENCY CONTACT (FOR PATIENT) **Please notate "same as above" is same as Next of Kin**

Full Name: _____ **Phone:** _____

Relationship to patient: _____

List ALLERGIES and INTOLERANCES to Medications: _____

☐ : **PLEASE TICK IF NO ALLERGIES KNOWN**

List REGULAR MEDICATIONS and DOSES: _____

Oxford Street Medical
Patient Consent to Collect, Use and Disclose Information

As a patient of our medical practice we require you to provide us with your personal details and full medical history, so that we may properly assess, diagnose, treat and be proactive in your health care.
The Privacy Act requires medical doctors to obtain consent from their patients to collect, use and disclose the patient's personal information. Please read the notice regarding the use of your health information on waiting room wall for further details.

Please read this consent form and sign where indicated below.

- I understand that Oxford Street Medical Centre complies with the Privacy Act 1998 and are committed to collecting, using, storing and disclosing my health information in accordance with The National Privacy Principles and keep my records accurate and up-to-date.
  I understand the need to communicate relevant health information to other treating doctors or Allied Health Professionals, e.g. referrals, requests for tests, to properly treat and be pro-active in your health care needs. I am also aware that this practice has a privacy policy on patient information.
- The purpose for collecting my health information is to provide quality medical care with associated account-keeping procedures in compliance with Medicare and the H.I.C.
- I understand that I can withdraw my consent for Oxford Medical Centre to use and disclose my health information, except when legal obligations have to be met. However, this action might compromise the quality of my health care and treatment given to me.
- I am aware that this practice uses a recall and reminder system to enable a systematic approach to health promotion and preventative care.
- I understand that I have the right to request access to my information, except in some circumstance where access can legitimately be denied.
- I understand that if my information is to be used for any other purpose, my further consent will be obtained.
- I consent to receive correspondence via SMS, telephone and post for Doctor requested appointments, appointment reminders and health information from Oxford Street Medical Centre.

Patient's Name: _____ **Date:** _____

Patient's Signature/ Guardian's Signature: _____