

# NEW PATIENT INFORMATION FORM

Clinic / Practice Name: \_\_\_\_\_

## Patient Personal Details:

Full Name: \_\_\_\_\_ Gender: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

## Emergency Contact Details:

Full Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_

## Medicare and Health Insurance Details:

Medicare Number: \_\_\_\_\_ Reference No.: \_\_\_\_\_

Health Fund Name: \_\_\_\_\_ Membership Number: \_\_\_\_\_

## Consent and Privacy Acknowledgment:

I acknowledge that I have read and understood the Patient Privacy Statement and Consent to the collection and use of my personal health information in accordance with the Australian Privacy Principles and relevant laws. I consent to the use and disclosure of my personal information as described in the Privacy Statement.

## Medical History:

Please list any medical conditions, allergies, current medications, or other relevant information that may affect your treatment:

## Patient Declaration:

I declare that the information provided on this form is accurate and complete to the best of my knowledge. I understand that withholding information may affect my treatment and care. I agree to notify the practice of any changes to my health or personal information.

**Patient Signature**

**Date**

Signature: \_\_\_\_\_

\_\_\_\_\_

**Privacy Statement Summary:**

Your personal information is collected, used, and stored in accordance with the Privacy Act 1988 (Cth) and the Australian Privacy Principles. This information is necessary for the provision of health care and may be shared with other health professionals involved in your care, or as required by law. You have the right to access and correct your information upon request.

**Contact for Complaints or Queries:**

If you have any concerns about the handling of your personal information, please contact the Practice Manager at the address or phone number provided above.

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