NUNDAH DOCTORS SURGERY
WAVELL HEIGHTS

New Patient Information

Title: Mr / Mrs / Ms / Miss / Master / Dr / Other **Birth Sex**: □ Male □ Female **Date of birth:** ...../...../.....

Gender Identity: ……. **Pronouns:** ……

First Name: …… **LastName:** ……

Preferred Name: …… **Email**: ……..

Address: ..... **Suburb**: ..... **Postcode**: …….

Phone: Home ..... Work ..... Mobile .....

Occupation: ..... **Weight kg:** …… **Height cm**:……

If Female – Date of your last cervical screening test:…… Result if known:……

Medicare: | | | | | | | | | | | **Ref No…**…… **Exp**……...

DVA No…… **Gold / White** If White Card, please specify condition……

Pension Concession / Health Care Card / Commonwealth Senior**…**…….. Exp……...

Is this visit Work Cover related? Yes / No WorkCover Claim No.**:** ……...

Case Manager**.**……. Contact No.**…**……..

Next of Kin: ..... Relationship: ..... Phone: .....

Do you consent for a family member / next of kin to: e.g: book an appt on your behalf / book ambulance or DVA transport / picking up referrals or scripts **(**please circle **YES / NO)**

Country of birth: ..... Ethnicity: …… Do you speak English? Yes / No

Do you require the services of an interpreter? Yes / No If yes: Language Spoken .....

Are you of Aboriginal or Torres Strait Island origin □ **Yes** □ **No** □ Not Provided

□ Aboriginal □ **Torres** Strait Islander □ **Aboriginal** and Torres Strait Islander □ Not Provided

□ **I** would like my doctor to provide medical management of my chronic health conditions via the Indigenous Health Incentive and/or PBS Co-Payment Measure (bulk-bill + cheaper/free PBS medicines)

Privacy Patient Information

To provide a high standard of medical care we need to collect personal information from our patients. Your information is treated with the strictest of confidence and will only be disclosed to a third party (e.g: health professional, insurance company etc) with your written consent. This information may also be collected from family members and other health care providers with the patient's consent, unless we are legally obliged to do so. Nundah Doctors Surgery ensures all information held is protected from loss, misuse or unauthorised access and all our staff are subject to strict obligations of confidentiality. We comply with the Privacy Act 1988 and the Australian Privacy Principles effective under the Privacy Amendment Act 2001.

Cancellation of appointment under 24hrs notice may incur $50.00 fee. No show appointment fee: $50.00
There will be a facility fee or consumable fee associated with use of the treatment room for procedures.

I have read the privacy statements, cancellation policy and consent:

Signature: _____ Date:_____

PAYMENT IS REQUIRED AT THE END OF THE CONSULTATION. ***WE DO NOT ACCEPT CHEQUES***
For more information, please see our Surgery Practice Brochure.

Nundah Doctors Surgery Wavell Heights

Health Information Collection and Use
Consent Form

As a patient of our medical practice, we kindly request your personal details and medical history to ensure thorough assessment, diagnosis, and proactive treatment of your healthcare needs.

We prioritise the protection and secure storage of your health information. You may request a copy of our privacy policy, which outlines how we collect, use, and disclose your health information.

Your consent is required for us to collect and use your personal information in the following ways. Please review this consent form carefully and sign below:

- Administrative purposes related to the operation of our medical practice

- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements

- Disclosure to healthcare providers involved in your treatment, including external specialists referred to for medical tests or reports

- Disclosure to other doctors within the practice and locums for patient care and teaching purposes

- Utilisation in research and quality assurance efforts to enhance individual and community healthcare and practice management. If identifiable information is needed, you will be informed and given the option to opt out

- Compliance with legislative or regulatory obligations, such as reporting notifiable diseases

- Sending reminder letters related to your healthcare and management.

You have the right to decline the use of your health information in part or in full as outlined above, although this may impact our ability to provide optimal healthcare outcomes for you.

By signing below, you confirm the following:

- You have reviewed the information provided and understand why your information is necessary.
- While you are not obligated to provide any requested information, failure to do so may affect the quality of healthcare and treatment.
- You are aware of your right to access the information collected about you, with exceptions explained where applicable.
- Any additional use of your information beyond what is stated above will require further consent.
- You consent to the handling of your information by our practice for the specified purposes, with any limitations on access or disclosures noted.

Patient Name: _____

Patient Signature: _____ Date: _____

Guardian Name: _____

Guardian Signature: _____ Date: _____