DR DAVID HAYES

New Patient Form

Please complete the following information.

PATIENT DETAILS

Title: ☐ Dr ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master ☐ Other

Surname:	**Given names:**
Preferred name:	**Date of birth:** ____ / ____ / _____
Home address:	

Email:		**Occupation:**
Home phone:	**Work phone:**	**Mobile:**
Next of kin:		**Contact no.:**

MEDICARE, BILLING AND HEALTH COVER

Name of person responsible for account:

Medicare number:	**Reference no.:**	**Expiry:** ____ / ____
Private hospital cover: ☐ Yes ☐ No		
Private health fund:	**Membership no.:**	
Veterans' Affairs number:	**Card type:** ☐ Gold ☐ White	

WORKERS' COMPENSATION

Current WorkCover claim: ☐ Yes ☐ No	**Claim no.:**
Date of injury: ____ / ____ / _____	**Insurer:**

MEDICAL INFORMATION

General practitioner's name and address:

Allergies (if any):

Other illnesses (e.g. diabetes, high blood pressure, asthma):

Current medication:

Reason for seeing Dr Hayes (e.g. right knee, left foot, hip):

Please complete and sign the Privacy Consent Form on page 2.

Privacy Consent Form

Please sign this consent form.

We require your consent to collect personal information about you. Please read this information carefully and sign where indicated below.

Our practice values the doctor-patient relationship. Protection of privacy is vital in the management of this relationship. The recent amendments to the Commonwealth Privacy Act formalise the already existing privacy obligations of our practice.

Our doctors and staff collect information primarily to provide quality health care. We require you to provide us with your personal details and full medical history so that we may properly assist, diagnose, treat and be proactive in your health care needs. This means we will use the information you provide in the following ways:

- Administrative purposes in running our medical practice;
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements;
- Disclosure to others involved in your health care, including treating doctors, specialists and allied health providers such as physiotherapists or occupational therapists outside this medical practice. This may occur through referral to other doctors or referral for medical testing and the subsequent reports or results returned to us following said referrals;
- Disclosure to other doctors, locums and to registrars attached to the practice, for the purpose of patient care and teaching. Please let us know if you do not want your records accessed for these purposes, and we will note your request accordingly;
- Disclosure for research and quality assurance activities, to improve individual and community health care, and practice management. You will be informed when such activities are being conducted and given the opportunity to ‘opt out’ of any involvement;
- Emergency situations whereby medical officers or hospitals require access to patient notes for treatment purposes.

Dr Hayes is a member of various medical and professional bodies, including medical defence organisations. These organisations provide valuable services to their members and ensure that the best interests of patients are maintained at all times. For ongoing quality assurance, it may be necessary for medical practitioners in the Centre to provide these organisations with information relevant to their practice. On occasion, this information may be patient-related.

I have read the information above and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling patient information.

I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and the treatment provided to me.

I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand that I will be given an explanation in these circumstances. Should I wish to access my information, I understand that the practice has a policy I must follow, which will be made available on request, and that an administrative charge may be levied for providing copies of my personal information.

I understand that if my information is to be used for any purpose other than set out above, my further consent will be obtained.

I consent to the handling of my information by this practice, for the purpose set out above, subject to any limitations on access or disclosure that I notify the practice of. These limitations will be provided to me in writing and will be added to my personal information already held by this practice.

Patient's name (please print):	_____	**Date of birth:**	_____
Signature:	_____	**Date:**	_____