NEW PATIENT DEMOGRAPHIC INFORMATION

# Helena Valley Medical Centre

We are committed to providing our patients with the best care. To ensure your health records are current, we request you please complete this form. Please do not hesitate to approach our staff for assistance or of you require an interpreter.

Surname: First name: Middle name(s):

Title: ☐Mr ☐Mrs ☐Ms ☐Miss ☐Dr ☐Other_____ Date of birth: / /

Sex: ☐Male ☐Female

Nationality: Language:

Is an interpreter required? Yes / No

Are you of Aboriginal or Torres Strait Islander descent?

☐ Aboriginal ☐ Torres Strait Islander ☐ Neither

| Home Address: | Suburb: | Postcode: |
|---|---|---|
| | | |

Postal Address (if different from above):

Phone Home: Phone Work: Phone Mobile:

| | | |
|---|---|---|
| Medicare Number: | Ref No: | Expiry Date: |
| DVA No: | Gold/White (please circle) | Expiry Date: |
| Health Care Card/Pension Card(please circle) | Card No: | Expiry Date: |

## EMERGENCY CONTACT DETAILS

| | |
|---|---|
| Next of Kin Name: | Next of Kin Address: |
| Next of Kin Relationship: | Next of Kin Phone: (1) (2) |
| Emergency Contact Name: | Emergency Contact Phone: |

**SMS consent (please tick)**

Do you consent to Helena Valley Medical Centre contacting you via SMS text message for appointment reminders, recall and other test reminders or medical services offered?

☐ **YES,** I consent SMS text message

☐ **NO,** I do not consent SMS text message

## PRIVACY STATEMENT AND FINANCIAL CONSENT

Your doctor will make independent professional decisions to optimise your clinical outcome. We value your privacy. All information about you, held at this practice, is kept in the strictest confidence. With the introduction of the Privacy Amendment (Privacy Sector) Act 2000 in December 2001, we remain committed to protecting your privacy and are now requesting your express consent for the use and disclosure of your personal health information. In the course of your health care, access to your personal health information is necessary to continue the high standard of service you have come to expect from us. Access to this information may be required directly or indirectly by other health care providers such as pathology services, pharmacists, specialists and health care facilities such as hospitals, disease monitoring agencies and Medicare.

Your personal health information will not be sold by this practice to marketing companies and cannot be used for the purpose of promoting non-health related products or services. I consent to the disclosure of my personal health information by doctors practicing at Helena Valley Medical Centre to other health care providers directly or indirectly involved in my personal health care or medical treatment. I consent to de-identified data (including, without limitation, photographs of my skin and any skin cancers) being used for medical training and medical research by Helena Valley Medical Centre and such data being provided to third parties for these same purposes.

**FINANCIAL CONSENT:** I have been advised of the estimated costs in respect of the proposed medical services. I accept responsibility for payment of this account, including (if applicable) if a nominated insurer does not pay the anticipated rebate.

**PERSONAL DECLARATION: I have read and understood the information provided above.**

_____ _____

Patient Signature( or Parent/Guardian if patient is under 16 years of age) Print Name of Patient/Parent/Guardian

Date: ____/____/_____

PATIENT NAME (Office use only)

BEST PRACTICE PATIENT ID