MOANA MEDICAL CENTRE

New Patient Form

Entered:

Scanned:

Welcome to our surgery. This form is designed to help us provide the best quality care. Our practice follows the guidelines of The Royal Australian College of General Practitioners Handbook for the management of health information in private medical practice. This means your personal health information is confidential and is kept private and secure, as required by federal and state privacy laws. If you have concerns, please leave blank and discuss with your GP.

Patient's details

Title: **Surname:** **Given names:**

Preferred name: Date of birth: / / ☐ Male ☐ Female

Marital status: ☐ Single ☐ Married ☐ Defacto ☐ Separated ☐ Divorced ☐ Widowed

Occupation: Religion:

Are you of Aboriginal or Torres Strait Island origin?

☐ Yes: If yes, please select ☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal & Torres Strait Islander

☐ No:

Country of Birth: Ethnicity:

Postal Address:

Home Address:

Phone: *(Home)* *(Mobile)* *(Work)*

Medicare number: Card position: Exp date:

☐ Pension ☐ Health Care Card ☐ Commonwealth Seniors Health Card

Number: Expiry Date:

☐ Veterans Affairs Number: ☐ Gold ☐ White

Person responsible for payment of account (Please complete if the patient is **under 18 years of age only**)

Title: Surname: Given names:

Postal address: Date of birth:

Home Address:

I understand that payment for medical treatment is to be made at the conclusion of each appointment unless other arrangements are made with the Practice Manager. I further understand that I may incur a non-rebatable fee should I not attend an appointment with appropriate cancellation notice. I also undertake to pay all debt collection expenses incurred should I default on overdue amounts.

Emergency contact *(next of kin)*

Title: Surname: Given names:

Address: Post code:

Relationship to patient: Phone: *(H)* *(M)* *(W)*

2nd Emergency contact *(If different from above)*

Title: Surname: Given names:

Address: Post code:

Relationship to patient: Phone: *(H)* *(M)* *(W)*

Please advise your doctor of any allergies of adverse drug reactions and your regular medications.
Please see over to acknowledge terms and conditions.

For completion only if we *will not* be your regular practice

If this is not your usual practice, your usual GP will be notified and any relevant information will be given, especially if follow up is necessary. Please provide your regular GPs contact details if you are happy for us to provide this:

General Practitioners name:

Practice name:

Practice address:

Phone: **Fax:**

Transfer of health information if we are to be your regular practice

You may have consistently consulted with a GP at another practice. The health information held by the GP may assist us with your future health care needs. You may wish to have a summary of your health records transferred to this practice.
Please ask the receptionist for information about how this can take place.

Consent

The details you have provided are used predominantly for your quality health care. Together with a full medical history discussed with your doctor, this information will be used to manage your health care needs. This includes referrals to other doctors and specialists, or for medical tests. It may also be used to comply with any legislative or regulatory requirements. Our management of your personal information complies with the Australian Privacy Principles as set out in the Privacy Act 1988.

Our practice undertakes professional development, quality assurance and accreditation, improvement activities and de-identified research to improve patient care. All professionals accessing personal health information for this purpose have signed a written confidentiality agreement.

Our practice sends all prescriptions electronically and may view the dispensing history of any of your prescriptions.

Our practice uses a reminder system to improve the quality of your health care. The practice sends reminders by SMS, mail or telephone for procedures such as vaccinations, Cervical Screening Tests and other health reviews as part of the quality improvement activities at this practice.

Prior to your appointment, a reminder will be sent via SMS to your mobile phone confirming the date and time of your booking. Please phone and advise us immediately if you are unable to attend your appointment.

Terms and conditions

- Full payment is expected at the time of consultation
- Pensioners and children 15 years and under will be direct billed to Medicare for routine consultations
- Patients 18 years and over are responsible for payment of their own account
- An out of pocket fee applies for procedures such as suturing and excisions
- **Compensation accounts:** This practice does not issue accounts for patients involved in third party/workers compensation cases. Full payment is required at the time of consult. Patients who are covered under Return to Work SA or Motor Vehicle Accident Insurance are reminded that THEY are responsible for ALL accounts incurred.
- **Failure to keep appointments:** A minimum $88.00 non-rebatable fee will be charged for non-attendance.
- ***We maintain high standards of professional behaviour, ethics and integrity in order to treat all patients with respect and courtesy. By signing this form, you agree to treat our staff respectfully in return. Aggressive and abusive behaviour will not be tolerated.***

I agree to the above policies, terms and conditions.

Signature of patient or guardian: _____ **Date:** **/ /**

Please advise us if your contact information or Medicare details change

The above practice policies are subject to change from time to time.
Changes are notified via notice boards, website and Practice Information Sheets.

How did you hear about us? _____