Mornington
Medical Group

NEW PATIENT INFORMATION

This information is important for you to obtain good health care. Please feel free to discuss with the reception staff or your doctor if you are unsure of anything or unable to fill in this form. As you are providing us with health information please also read and sign the consent form to allow us to collect and use your health information.

Personal Details

Surname: _____ First Name: _____

Date of Birth: _____/____/____ Title: Miss/Mrs/Ms/Mr/Mast Gender: _____

Email: _____ Ethnicity: _____

Address: _____ Suburb:_____

Phone No: Home:_____ Work: _____Mobile:_____

Aboriginal/Torres Strait Islander: Yes/No Any Religious Affiliation:_____

Medicare No: _____ Expiry: ___/___ Medicare Ref No: _____

If Applicable:

Pension Number: _____ Expiry: ___/___ HCC No: _____ Expiry: ___/___

DVA Card No: _____Expiry: ___/___ Workcover Claim No: _____

Current Occupation: _____ Or School:_____ Year: _____

Any custody issues we need to be informed of: _____

Preferred Language: _____Any special needs?: _____

Emergency Contact/Next of Kin:_____ Relationship to you: _____

Contact No: _____

Appointments

Appointment times are scheduled for 15 minutes or longer if required and can not be booked on line through our website – www.morningtonmed.com.au. If you are unable to attend an appointment please let us know within 24 hours of your appointment time or this could incur a cancellation fee.

Electronic Communication

Patient communication/appointment reminders may be communicated via electronic means (e.g. SMS, Fax and Email) and is conducted with appropriate regards to the Victorian Information Privacy Act 2000, the Health Records Act 2001 or the Privacy Act 1988 (Commonwealth) as applicable. Mornington Medical Group takes every care to ensure that electronic messages will be private

Health Information Collection and Use Consent Form

As a patient of our Medical Practice we require you to provide us with your personal details and a full medical history, so that we may properly assess, diagnose, treat and be proactive in your health care needs.

We aim to protect the privacy and secure storage of your health information. You can request a copy of our privacy policy which includes information about the collection, use and disclosure of your health information.

We require your consent to collect personal information about you and to use the information you provide the following ways. Please read this consent form carefully and sign where indicated below.

- Administrative purposes in running our medical practice
- Billing purposes, including compliance with Medical and Health Insurance Commission requirements
- Disclosure to others involved in your healthcare including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or medical tests and in the reports or results returned to us following referrals.
- Disclosure to other doctors in the practice, locum etc. attached to the practice for the purpose of patient care and teaching,
- For research and quality assurance activities to improve individual and community health care and practice management. Usually information that does not identify you is used by should information that will identify you be required you will be informed and given the opportunity to "opt out" of any involvement.
- To comply with any legislative or regulatory requirements e.g. notifiable diseases.
- For reminder letters which may be sent to your regarding your health care and management.
- Payment in full is requested at the time of consultation. A $20 non attendance fee will be charged for consults not cancelled within 24 hours

You can decline to have your health information used in all or some of the ways outlined above but it may influence our ability to manage your health care to provide the best outcome for you.

I have read and information above and understand the reasons why my information must be collected ☐

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

I am aware of my rights to access the information collected about me, except in some circumstances where access may be legitimately withheld. I will be given an explanation in these circumstances. ☐

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

I consent to the handling of my information by the practice for the purpose set out above, subject to any limitations on access or disclosure of which I notify this practice ☐

OR

I am unsure and would like to discuss this further with someone from the medical practice before I sign. ☐

Patients Name_____ Date _____/_____/_____

Patients Signature_____

Parent/Guardian Signature_____ Name (printed)_____