SANDRINGHAM
MEDICAL CENTRE
Total Health Care

New Patient Information Sheet (Baby/ Child)

Please fill in, and then hand back to the reception desk. (Retain the last page & hand in to your doctor)
Please use block letters when filling out form.

Todays date: _____

How did you hear about us? (Please tick)

Internet (specify) Google: _____ **Search engine:** _____ **Family:** _____ **Other:** _____

Today's Date: _____ **Preferred Title:** (ie Master, Miss) _____

Full Name _____

Address _____

_____

Phone:
Home _____ Mobile _____ Work _____

Date of Birth _____ **SMS Confirmation: Yes** _____ **No** _____

Responsible account holder details?

Name: _____ D.O.B. _____

Are you: (Please tick) Aboriginal _____ Torres Strait Islander _____ Neither _____

Medicare Card number _____ Ref # _____ Expiry: _____

Veterans Affair's card number _____ Expiry: _____

Aged Pension Concession Card number: _____ Expiry: _____

Please nominate a contact person/ NOK in case of an emergency:

Name _____ Phone: _____

Relationship to patient: _____

We respect your Privacy

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

The Doctors of Sandringham Medical Centre collect information from you for **the primary purpose** of **providing quality health care.** 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. You will be registered for a My Health Record at Sandringham Medical Centre. We will use the information you provide in the following ways:

- Administrative purposes in running our medical practice
- Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, My Health Record or for medical tests and in the reports or results to us following the referrals.
- Disclosure to other doctors in the practice and Locums or 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 record accordingly.
- Disclosure for research and quality assurance and 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.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.

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 health care and treatment given to me.

I am aware of my right to access the information collected about me, except in some circumstances where access might be legitimately withheld. I understand I will be given an explanation in these circumstances by my doctor. This access might be by inspection of my history at the time of appointment in the presence of a medical practitioner, or copying of information at other times. Both of these would incur a cost to me non-refundable from Medicare.

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 this practice for the purpose set out above, subject to any limitations on access or disclosure that I notify this practice of.

Patient name _____

Signed _____ Date _____

I understand that Sandringham Medical Centre is a private billing clinic and that there is a fee for service. In the event where your overdue account is referred to a collection agency and/or law firm, you will be liable for all costs which would be incurred as if the debt is collected in full, including legal demand costs. 24.06.16

MEDICAL HISTORY – (Parent to complete)

***Please fill this page in and hand it to your doctor at the beginning of your consultation:**

Patient name: _____

Please provide details of any significant **religious or cultural information** that may be relevant to your medical treatment:

_____

Please provide information in relation to any **significant medical issues** (e.g. Operations, Major Illness)

_____

_____

Please provide details of any **significant current medical problems** (e.g. Diabetes, Heart Disease etc)

_____

Current Medications: (please list) _____

_____

_____

Allergies _____

_____

_____

***Office use only**

ENHANCED PRIMARY CARE SERVICES ELIGIBILITY

SERVICE (please tick)	YES	NO	Maybe?
HMR – Home Medication Review			
Health Assessment – 45 to 49 year old			
Health Assessment – 75+ year old			
GPMP			