mt martha
village clinic

# New patient Registration Information and Consent Form

## CONTACT INFORMATION

Title: MR/MRS/MISS/MS/DR/NA Family Name: .....

Given Name: ..... Preferred Name: .....

DOB: ..... Birth sex: ..... Gender identity: ..... Pronouns: .....

Address: ..... Post code: .....

Postal Address: ..... Post code: .....

Contact numbers: Home: ..... Mobile: ..... Work: .....

Email: .....

## EMERGENCY CONTACT DETAILS

Name: ..... Relationship to you: .....

Home phone: ..... Mobile: .....

## NEXT OF KIN DETAILS

Name: ..... Relationship to you: .....

Home phone: ..... Mobile: .....

## HEALTHCARE IDENTIFIERS

Medicare number: ..... IRN: ..... Expiry: ...../.....

Dept of Veterans' Affairs Number: ..... ❒ Gold White ❒ White card

Concession Card (Pension/Health Care) Card Number: ..... Expiry: ...../.....

## CULTURAL IDENTITY

To assist Indigenous Australians with health initiatives - Do you identify as an Aboriginal and/or Torres Strait Islander person? ❒ No Australian non-indigenous ❒ Yes – Aboriginal ❒ Yes – Torres Strait Islander

❒ Yes – Aboriginal and Torres Strait Islander

Country of birth: ..... Pref language if other than English: .....

As Australia is a multicultural society, and to tailor to appropriate care, understanding and appreciation between people from different nationalities and cultures – do you identify as someone from a culturally and/or linguistic diverse background?

❒ No

❒ Yes – please say more:

If yes, Do you require an interpreter service? ❒ Yes ❒ No

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## HEALTH INFORMATION

**ALLERGY** – Are you allergic to any drugs, medications, anaesthetics or dressings?

❒ No ❒ Yes – please provide details

| Drug, Dressing or Substance | Reaction (eg rash, hives, wheeze, anaphylaxis) |
|---|---|
| | |
| | |
| | |

**CURRENT MEDICATIONS** – Please list all current medications, doses and frequency of use including complementary and over the counter medications, vitamins and minerals:

……

……

……

**MEDICAL HISTORY** – Do you have or have you had a history of the following?

❒ Surgery – provide details:
❒ Asthma
❒ Diabetes
❒ High blood pressure
❒ Chronic illness
❒ Other – please provide details:

Females please note: Your last Cervical screening test: Date: ……..

**LIFESTYLE RISK FACTOR**

Smoking: ❒ Never ❒ No – ceased date: …….. ❒ Yes – how many ……. / day, ……. / week

Alcohol: ❒ Never ❒ Yes – how many drinks …… / day, …… / week …… /month

Recreational Drug Use:

❒ No ❒ Yes - pls list type and frequency: ……

## FAMILY HISTORY

Have any family members had any of the following problems:

❒ Heart Disease
❒ High blood pressure
❒ Diabetes
❒ Mental illness
❒ Cancer – type ……..
❒ Other significant – please provide details

……

……

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## PATIENT CONSENT

Your GP is committed to providing you with quality health care and collects information from you with this purpose in mind. It is required that you provide your GP with your personal details and full medical history so that you may be properly assessed, diagnosed, treated and be proactive in your health care needs.

In keeping with obligations under Privacy Act 1988 (Commonwealth) and Australian Privacy Principles and under State health records legislation, please be informed of the purposes for which your GP, nurse and administrative teams at this clinic may use your personal information and how your personal information is used and disclosed (including health information).

Please provide your consent to collect your personal information, and for its use in the following ways:

- Administration purposes in the operation of this practice.
- Billing purposes including compliance with Medicare.
- Disclosure to others involved in your healthcare, including your treating GP and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to your GP following referrals.
- Your GP may use an AI agent for transcriptions purposes using platforms that fully complies with the Australian Privacy Principals
- Disclosure to other GP's and nurses in the practice for the purpose of patient care and teaching.
- For Accreditation, research and quality assurance activities to improve individual and community health care and practice management. Only information that does not identify you is used in these circumstances.
- To comply with any legislative or regulatory requirements such as notifiable diseases or if legally compelled to do so.
- For reminders and recalls which may be sent to you regarding your health care and management.
- There may be circumstances where your GP will be obliged to release details of your health information without your express consent – this may be in the case of extreme emergency.

## COMMUNICATION BETWEEN PRACTICE AND PATIENT

Your GP is committed to providing patients with quality health care. As part of their commitment, Mt Martha Village Clinic has implemented technology solutions to enable communications with our patients via SMS and mobile applications.

In addition to other communications that may be sent to you from time to time, are the following types of communications:

1.) Appointment reminders – notifications to you to remind you of upcoming appointment dates with your GP or nurse at the practice as well as allowing you to confirm your appointment;
2.) Clinical reminders – notifications to you to remind you to contact the practice to arrange appointments for regular clinical check-ups, medical procedures, immunisations due;
3.) Clinical communications – communications to you about your clinical care at the practice such as returned pathology results or clinical messages from your GP; and

4.) Health awareness – communications to you in relation to general health care information and health care services provided at Mt Martha Village Clinic including notifications about changes to our clinic opening hours and information about health care services provided by Mt Martha Village Clinic.

As part of the provision of health care services to you, you will be sent appointment reminders, clinical reminders and clinical communications from time to time. You may also be sent health awareness information if you have consented to receive such communications below. Your information (including health information) may be disclosed to third party service providers (which may be located outside of this state) to assist us in sending you any information that is unencrypted. For example, if we send you an sms, your details are disclosed to the carrier that MMVC engages in order to get that message to you. So when you are provided with instruction or information regarding your personal health, it is done with simple, direct terms via sms or email and any sensitive information is kept for face to face consultation.

To the extent practicable, communications will be sent via your preferred contact method indicated below. However, you acknowledge that we may contact you using any of your contact details that you may provide to us from time to time as we consider appropriate.

## ACKNOWLEDGEMENT AND CONSENT:

I have read the 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 if I choose not to, then I may compromise the quality of health care and treatment provided to me.

I acknowledge and agree that, in the course of providing health care services to me, my GP and Mt Martha Village Clinic may need to use and disclose my personal information (including any health information) as set out in this form.

I wish to receive health awareness communications as described above and I hereby specifically consent to the use of my personal information, including any health information by my GP and Mt Martha Village Clinic to assess the types of health awareness communication that is sent to me and specifically consent to receipt of such health awareness communications.

I acknowledge that my GP and Mt Martha Village Clinic will use contact details provided by me (as updated by me from time to time) to communicate with me. To the extent that the mobile number I have provided to Mt Martha Village Clinic is utilised by more than one patient, I understand and consent that all SMS and phone communications will be directed to that number.

Please complete and sign below if you understand and agree to the acknowledgements and consent set out above.

Patient Name (please print): ……..

Parent/Guardian Name if patient is under 16: ……..

Your relationship to patient (eg mother, father, guardian) ……

Signature: …… Date: …….