



New Patient Form

Please fill out form and answer **all** questions as **much as possible**. **All information** will be kept confidential.

Title (Please circle)	Miss / Ms / Mrs / Dr/ Mr / Mast / Other: _____		
Family Name			
Given Name			
Preferred Name			
Date of Birth		Birth Sex (Please circle)	Male / Female / Other
Pronouns (Please circle)	He/Him/His; She/Her/Hers; They/Them/Theirs	Gender:	
Identify with as Aboriginal or Torres Strait Islander?	Aboriginal Torres Strait Islander Both Neither		
Ethnicity (Cultural Background)	(e.g Australian, Chinese, Italian, Greek etc.): _____		
Country of Birth		Preferred Language:	
Address	Street Address: _____ Suburb: _____ State: _____		
Postal Address (If different to address above)			
Home Phone		Work Phone	
Mobile Phone			
Email Address			
Medicare Number	Number: _____ Ref: _____	Expiry Date	
DVA Number: (Please circle)	Gold White Number: _____	Expiry Date	
Concession Card Type	Health Care Card Pensioner Concession Card Commonwealth Seniors Card		
Concession Card Number		Expiry Date	
Occupational/ Employment			
Marital Status (Please circle)	Single Married De-facto Separated Divorced Widowed		
Sexuality (Please circle)	Heterosexual Homosexual Bisexual Prefer Not to Say		
Next of Kin	Name: _____ Contact number: _____ Relation to you: _____		
Emergency Contact (A person we can contact if necessary- e.g. neighbour, friend)	Name: _____ (A person other than Next of Kin) Contact number: _____ Relation to you: _____		

Please Turn Over

Consent for Reminders:

Our practice uses a system for appointment and health reminders (e.g. Immunisation, annual health checks, cervical screening, and other health reviews). The practice sends these reminders by either post, email, telephone, or SMS.

I consent to being contacted with reminders:

☐ Yes ☐ No

Our practice also sends information to the Australian Immunisation Register and Cervical Screening Register. These registers also send reminders, which can be helpful if you move.

I consent to being contacted with reminders from other registers:

☐ Yes ☐ No

Consent for Email

I understand the risks of using email which may include but are not limited to

- Email may be seen by unintended viewers if addressed incorrectly.
- Email may be intercepted by hackers and redistributed.
- Someone posing as you could access your information.
- Email can be used to spread computer viruses.
- There is a risk that emails may not be received by either party in a timely matter as it may be caught by junk/spam filters.
- Emails can be circulated and stored by unintended recipients.
- Statements made via email may be misunderstood thus creating miscommunication and/or negatively affecting treatment.
- There may be an unanticipated time delay between messages being sent and received.

I consent to Camberwell Medical group to send me through my email address filled in this form correspondences related to my medical records:

☐ Yes ☐ No

I confirm that the information I have given is correct. I consent to sharing of all relevant information between the GPs, Specialists, Nurses, Allied Health providers and non-clinical staff for the purpose of managing my health. I understand this information will be used to fulfill their duties in the course of planning and management of my health. Your health information will be treated with the utmost confidentiality. Disclosure will not be made without your prior consent. A copy of our Privacy Policy is available at Reception. Please sign this form as confirmation that you have read and understood our Privacy Policy, and consent to the use of your health information in this way.

Patient's Signature _____ **Date** _____