Office Use Only:
Form Completed by patient ☐
M/Card Sighted ☐
Admin Initials: _____

Modern Medical Clinics - New Patient Form

This information is private and confidential and used in conjunction with your clinical file only.
It is a requirement that all files contain this information for accreditation purposes.
Please give us as much detail as possible to assist us to provide quality care.

NEW PATIENT DETAILS: *(Please print clearly or circle where required)*

Title:_____First Name(s):_____ Surname: _____

Preferred Name: _____DOB:_____Occupation:_____

Ethnicity: Australian Aboriginal TSI Other:_____ Cultural Background:_____

Address: _____

Suburb: _____ State: _____Post Code: _____

Postal Address if different to above: _____

Telephone: (H): _____(M):_____ (W):_____

Email Address: _____

Medicare No: _____ Ref: _____ Exp: _____

HCC/PENSION: _____ Exp: _____

DVA No: _____Card Colour:_____ Exp: _____

Next of Kin:

Title: _____First Name: _____Surname:_____

Relationship: _____ Phone: _____

Emergency Contact: (MUST BE DIFFERENT FROM NEXT OF KIN)

Title:_____ First Name:_____ Surname:_____

Relationship:_____ Phone: _____

☐ I consent to registering to **My Health Record** (an electronic summary of an individual's key health information) & allowing my summary to be uploaded by my Healthcare Provider.

☐ I consent to SMS/Email notifications (ie recalls/ reminders/ results) to be sent to me from Modern Medical Clinics when this free service becomes available.

How did you hear about us? (ie Google, newspaper, word of mouth):_____

PATIENT SIGNATURE:_____ DATE:_____ Please turn over →

66-70 Mahogany Drive, Halls Head WA 6210
GP Phone: (08)9582 7800 Fax: (08)9535 8390 Skin Check Phone: (08)9535 2400 Fax: (08)9535 8390
Email: mail@modernmedicalclinics.com.au Web: www.modernmedicalclinics.com.au

PATIENT HISTORY: *(Please list where required)* Current Medications:

_____
_____
_____
_____
_____
_____
_____
_____

Do you have any significant health problems?

_____
_____
_____
_____

Do you have any Allergies or Drug Reactions?

_____
_____
_____
_____
_____

SOCIAL HISTORY:

☐ Tobacco:_____day/week or Ceased Smoking date: _____

☐ Alcohol: _____day/week

☐ Drug use (type & frequency):

_____
_____
_____

Do you know your Height:_____cms Weight:_____kgs

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Modern Medical Clinics

CONSENT TO COLLECTION OF PERSONAL AND HEALTHCARE INFORMATION

As a patient of this 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 of your health information at all times. 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 your personal information, and its use for the following reasons:

- Administrative purposes
- Billing purposes (including compliance with Medicare and Health Insurance Commission requirements)
- Disclosure to others involved in your healthcare. This may include your treating doctor, allied health professionals, other specialists and health practitioners outside of this practice. This may occur through referral to others or for medical tests and in the reports or results returned to us following referral.
- Disclosure to other doctors in the practice for the purposes of patient care and teaching.
- For research and quality improvement purposes to improve individual and community health care and practice management (this will only be information that does not identify individual patients)
- To comply with regulatory or legislative requirements such as notifiable diseases or where the health and well-being of you or other/s is at significant risk of harm.
- For reminders and recalls regarding your healthcare and management.

You can decline to have your health information used in all or some of the ways outlined above, but it may influence the practice's ability to manage your healthcare to provide the best outcome.

PLEASE READ EACH STATEMENT CAREFULLY AND TICK THE BOX IF YOU AGREE	
I have read the information above and understand the reasons why the 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 or if I provide information but want to put limitations on access or disclosure, I will discuss these with the practice beforehand.	
I understand that if my information is to be used for any other purposes other than those set out above, my further consent will be obtained.	
I consent to the handling of my information by the practice for the purposes set out on this form.	
I understand that depending on the age of my child, and given my child's right to privacy, in the clinical judgment of the doctor treating my child I may be prevented from access to information regarding my child's healthcare.	
I understand and consent to be contacted and receive reminders about my healthcare and management.	
OR	
I am unsure and would like to discuss further with someone from the medical practice before signing	

Patient Signature: _____ D.O.B:_____

Patient Name *(Please print)*: _____

(IF PATIENT IS UNDER THE AGE OF 16YRS OR UNABLE TO SIGN PLEASE FILL IN BELOW)

Parent / Guardian Signature: _____

Parent / Guardian Name *(Please print)*:_____

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