Surf Beach Surgery

New Patient Information Form

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Master ☐ Dr ☐ Ms ☐ Other ______________

Gender Identity: ☐ Male ☐ Female ☐ Non-Binary ☐ Transgender ☐ Other ________

Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them **Date of Birth:** _____ / ____ / _____

First Name: ____________________________ **Middle Name:** ______________________________

Family Name: __________________________ **Preferred Name (E.g. "Jo"):** ___________________

Address: ____

Mobile:_______________________________ **Home Phone:** _______________________________

Email: ____

Occupation: ____

Do you identify as: ☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal & Torres Strait Islander

Ethnicity (E.g. "Australian"): ____

Medicare Number: ____

Individual Reference Number: ______________________ **Expiry:** ________________

Concessions: ☐ Pension (Age, DSP) ☐ Health Care Card ☐ Seniors Card

Concession Card Number: _____________________________________ **Expiry:** ________________

DVA File Number: _________________________________ **Entitlement Number:** _______________

Expiry: ________________ **DVA White Card Conditions:** ________________________________

Emergency Contact

First Name: _________________________

Family Name: _______________________

Relationship: ________________________

Phone: _____________________________

Next of Kin

☐ Same as Emergency Contact

First Name: _________________________

Family Name: _______________________

Relationship: ________________________

Phone: _____________________________

Surf Beach Surgery

Patient SMS Consent

The purpose of this form is to inform you and seek your consent to the use and disclosure of your personal information (including health information) in regards to our reminders and notifications systems within our practice. Surf Beach Surgery is committed to providing our patients with quality health care. As part of our commitment, we have implemented technology solutions to enable communications with our patients via SMS.

Please refer to our privacy policy for more information on the management of personal information by Surf Beach Surgery.

Acknowledgements and Consent
I acknowledge and agree that, in the course of providing health care services to me, Surf Beach Surgery may need to use and disclose my personal information (including health information) as set out in this form. I wish to receive communications (as directed above) and I hereby specifically consent to the use of my personal information (including any health information) by Surf Beach Surgery to assess the types of health awareness communication it sends me and specifically consent to the receipt of such health awareness communications.

In addition to other communication we may send you from time to time, we may send you the following types of communications:

- **Appointment reminders** – notifications to remind you of upcoming appointment dates with the practice as well as allowing you to confirm your appointment
- **Clinical reminders** – notifications to remind you to contact the practice to arrange appointments for regular clinical check-ups, medical procedures or immunisations
- **Clinical communications** – communications about your clinical care such as returned pathology results or clinical messages from your medical practitioner
- **Health awareness** – communications to you regarding general health care information and health care services provided by Surf Beach Surgery

We may use a third party service and disclose your personal information (including health information) to them, to assist us in sending you the above communication. To the extent practicable, we will send you communications via your preferred contact method, however we acknowledge we may use any contact information you have provided to communicate with you as we consider appropriate.

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

Patients Name: ____________________________________ **Date of Birth:** _____ / ____ / _____

Preferred contact number (mobile): ____

Signature: ____ **Date:** ________________________

(Parent/Guardian Name if Patient Under 18): ____

Surf Beach Surgery

Collection, Use and Disclosure of Personal Information

Surf Beach Surgery aims to protect the privacy and secure storage of your health information. Yu can request a copy of our privacy policy, which includes information about the collection, use and disclosure of your health information. You have the right to decline to have your personal health information used in some of the way outlined below, but this may limit our ability to manage your health care and provide you with the best outcome.

Surf Beach Surgery will collect your personal information for:

- Communications regarding treatments, notifications about recommended preventative health care services and appointments, and for accounting and billing purposes
- The diagnosis & treatment of health conditions, including disclosure to other doctors in the practice, specialists, locums and other health care providers to ensure quality patient care
- Accreditation and quality assurance activities within the practice, using de-identified aggregate patient health information
- To allow medical students and staff to participate in medical training and teaching, using de-identified aggregate
- Patient health information

Disclosure of personal information
Surf Beach Surgery will not disclose your personal information to a third party unless:

- You have consented to the disclosure
- In accordance with the Privacy Act (1988), the disclosure is to your responsible carer, if you are physically or legally incapable of giving consent to the disclosure or for compassionate reasons, unless there is good evidence of your wish to the contrary
- Where legally obliged to disclose the information
- Disclosure is necessary to prevent a serious or imminent threat to an individual's life, health or safety or to prevent a criminal offence or seriously improper conduct
- It is required for judicial, administrative or coronial proceedings or is requested under a court order or subpoena
- It is the subject of a search warrant or is required to help identify or locate a patient

Full or partial access to your medical records may be refused in circumstances where:

- Disclosure of health information may result in physical harm or mental harm to you or any other person
- The information may impact on the privacy of other individuals
- Information relates to existing or anticipated legal proceedings

I consent to Surf Beach Surgery handling my information for the purposes set out above, and I understand that I can request a copy of the Surf Beach Surgery Privacy Policy at any time.

Patients Name: ____

Signature: ____ **Date:** _________________

Registration Form

MyMedicare is a voluntary patient registration model. It aims to formalise the relationship between patients, their

general practice, general practitioner (GP) and primary care teams.

MyMedicare patients and their usual GP and practice will have access to new benefits to help deliver more of the care patients need, improving health outcomes.

Patient Details

Family name

First given name **Second given name**

Date of Birth

Medicare Number or DVA File Number **Medicare IRN**

Practice and Provider Details

Practice Name and Practice Address

Name of Preferred GP

By signing this form I agree to the following:

I understand that registering in MyMedicare is voluntary.

1. I consider this Practice to be my regular primary health care provider.
2. I understand that I can only be registered with one Practice at a time. By submitting this form, any existing registration in MyMedicare will be withdrawn, and my previous Practice and provider will automatically be notified that I am no longer registered with them under MyMedicare.
3. I understand that I will remain registered unless:
    - I register with a different Practice.
    - I request my GP/Practice or Services Australia to withdraw my registration.
    - My GP or Practice decides to withdraw my registration.

4. I understand that there is no cost to register in MyMedicare.
5. I declare I have read and understand the MyMedicare Privacy Notice and consent to my personal information being collected, used and disclosed by the relevant agencies such as Services Australia, the Department of Health and Aged Care, the Australian Digital Health Agency and, where applicable, the Department of Veterans' Affairs as specified in the MyMedicare Privacy Notice (a link to this notice is provided in the Privacy Statement at the bottom of this form).

Full name of individual providing consent (Patient, patient's guardian/attorney or parent if required)	
Signature	Date 05/09/2024

If a parent or guardian has completed this form on behalf of a patient aged 14-17, please confirm the patient is aware of this registration and provided informed consent. ☐ Yes

Consent for MyMedicare registration for patients under 14 years of age must be provided by the patient's parent or legal guardian.

Patients aged 14-17 years must provide their consent to register for MyMedicare.

- A parent or guardian of a patient aged 14-17 years may complete the Registration Form if the 14-17 year old is aware of the registration and has provided their consent for this person to act on their behalf.

For a patient 14 years or older, who lacks capacity to make decisions for themselves, consent for the MyMedicare registration will need to be provided by an individual who is authorised to act on the patient's behalf.

Office use only
Provider Number of preferred GP____
Please select a box to confirm the patient's eligibility
☐ The patient has had at least 2 face-to-face consultations at the Practice in the previous 24 months
The patient meets the reduced eligibility criteria of at least one face-to-face consultation at the Practice in the previous 24 months and
☐ The Practice is located in MMM6-7
The patient meets one of the exemption criteria:
☐ Children under 18 years whose parent is already registered at this practice
☐ Parents of a child under 18 years who is already registered at this practice
☐ Patient is following a GP they are registered with to this practice
☐ Patient experiencing family and domestic violence
☐ Patient experiencing homelessness

Privacy Statement

The law regulates how Services Australia, the Department of Health and Aged Care, the Australian Digital Health Agency and the Department of Veterans' Affairs may handle your personal information. Services Australia is collecting your personal information to assess your eligibility for MyMedicare and provide services to you and payments linked to your provider as a result of your MyMedicare registration. Your information will only be shared with relevant government agencies such as the Department of Health and Aged Care, Australian Digital Health Agency and the Department of Veterans' Affairs, where you have agreed, or where the law allows or requires it. The MyMedicare Privacy Notice describes how your information will be managed consistent with our obligations under the *Privacy Act 1988* and the *Australian Privacy Principles.* The notice can be found at MyMedicare – PrivacyNotice
You can also read the:

- Services Australia privacy policy at: www.servicesaustralia.gov.au/privacy
- Department of Health and Aged Care privacy policy at: https://www.health.gov.au/resources/publications/privacy-policy
- Australian Digital Health Agency privacy policy at: https://www.myhealthrecord.gov.au/about/privacy-policy, and
- Department of Veterans' Affairs privacy policy at: https://www.dva.gov.au/privacy-policy.
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