

## GOLD COAST VASECTOMY

### NEW PATIENT FORM.....*Welcome to our practice*

*Please complete this form and bring to reception 10 minutes before your initial consultation*

We need this information to provide you with the best quality of care. Our practice follows the guidelines of The Royal Australian College of General Practitioners Handbook for the management of health information in private medical practice. This means your personal health information is kept private and secure, as required by federal and state privacy laws. If you wish to review our full privacy policy please request a copy from one of our reception staff.

#### **PATIENT DETAILS**

Surname \_\_\_\_\_ Given Names \_\_\_\_\_ Title \_\_\_\_\_

Date of birth \_\_\_/\_\_\_/\_\_\_

Are you of Aboriginal or Torres Strait Islander origin? Yes No If Yes, please advise \_\_\_\_\_

Home address \_\_\_\_\_

Postal address \_\_\_\_\_

Phone (*home*) \_\_\_\_\_ (*mobile*) \_\_\_\_\_

E-mail \_\_\_\_\_

Medicare Card Number \_\_\_\_\_ / \_\_\_\_\_ Expiry date \_\_\_\_\_

Veterans' Affairs Card Number \_\_\_\_\_ Expiry date \_\_\_\_\_

Health Care Card Number \_\_\_\_\_ Expiry date \_\_\_\_\_

Pension Card Number \_\_\_\_\_ Expiry date \_\_\_\_\_

#### **EMERGENCY CONTACT (*next of kin*)**

Name \_\_\_\_\_ Relationship to you \_\_\_\_\_

Phone (*home*) \_\_\_\_\_ (*mobile*) \_\_\_\_\_

How did you hear about our practice?

Family Internet GP \_\_\_\_\_

Friends Yellow pages Other (please specify) \_\_\_\_\_

#### **Cancellation Policy**

We ask that if you cannot make your scheduled appointment you contact us as early as possible. This will ensure other people do not miss out on available appointments. Failure to give us notice may incur a late cancellation fee.

*Please turn over...*

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### Privacy Patient Information

To provide a high standard of medical care our practice undertakes research, professional development, and quality assurance/improvement activities. Any person accessing personal health information for this purpose has signed a written confidentiality agreement.

I consent to my health record being reviewed as part of the quality improvement activities at this practice  
Yes                      No

At times some of your medical information may need to be shared with other health care providers. Our practice uses encrypted e-mail as a form of communication with other health professionals, for example, specialists.

I am aware there may be a small risk in transmitting information, however, I consent to my medical information being transmitted via encrypted electronic communication or fax (**N.B.** if you answer No to this question then you are required to take paper copies of all documents, including referrals to other healthcare providers, insurance companies, etc)                      Yes                      No

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