**East Brunswick Medical Centre New Patient Information Form**

This information is required to provide the best quality care. This form complies with the RACGP standards for general practices (5th edition). This means your personal health information is kept private and secure, as required by federal and state privacy laws. If you have concerns, please leave blank and discuss with your GP.

Please notify us promptly of any changes in your contact details. Accurate contact details help us identify you and your medical records, and allow us to contact you promptly about tests and results.

**🞏 Dr Andrew Osborne 🞏 Dr Raymond Wen 🞏 Dr Radhika Sheorey 🞏 Amanda Wright 🞏 Dr Claire Veith**

**🞏 Dr Leigh Guy** **🞏 Dr Kerryn Gijsber****s 🞏 Dr Amanda Burnside 🞏 Dr Laura Beaton**

**Personal Details:**

**Surname                                     First Name:**

**Middle Name:                                 Date of Birth:         /          /                Title:**

**Gender:                                       Pronouns:**

**Residential Address:**

**Postal Address:**

**Mobile: Home phone: Work phone:**

**Are you Aboriginal or Torres Strait Islander origin? 🞏 No 🞏 Yes, Aboriginal 🞏 Yes, Torres Strait Islander 🞏 Yes, both Aboriginal and Torres Strait Islander**

**Medicare Card Number: \_** **\_   \_  \_  \_  \_  \_  \_  \_  \_  Reference: \_**   **Expiry Date: \_   \_/\_    \_**

**Pension Card OR Health Care Card (Please circle)**

**Number: \_   \_   \_  \_  \_  \_  \_  \_  \_      Grant date: \_   \_/\_   \_/\_\_     \_\_ Expiry date: \_   \_  /**

**Email address:**

**Marital Status: 🞏Single 🞏Partner 🞏Defacto 🞏Married 🞏Separated 🞏 Divorced 🞏Widowed 🞏Child**

**Ethnicity:                                    Country of Birth:                                                         Language:**

**Do you require an interpreter? 🞏 Yes** 🞏 **No**

**How did you hear about EBMC?**

**🞏Internet** **🞏Phone Book** 🞏**Word of Mouth** 🞏**Referred by existing patient** 🞏**Clinical Referral**

🞏**Walking past** 🞏**Returning Patient**

**NEXT OF KIN**

**Name: Contact phone:     Relationship to you:**

**EMERGENCY CONTACT:**

**Name: Contact phone:     Relationship to you:**

**Do you have an Advance Care Directive for end-of-life care?** 🞏 **Yes** 🞏 **No**

***PATIENT CONSENTS***

**YES 🞏 NO 🞏**

**I consent to being contacted by the practice via SMS?**

**YES 🞏 NO 🞏**

**I consent to the practice using email to communicate with me?**

**I consent to the practice sending relevant information to 3rd parties (e.g., National Cancer Screening Register). These organisations may contact you for reminders relevant to your ongoing healthcare.**

**YES 🞏 NO 🞏**

**I consent to the practice uploading relevant information to my Shared Health Summary following discussion and consent from me.**

**YES 🞏 NO 🞏**

**YES 🞏 NO 🞏**

**I consent to being included in anonymous data collection for the purpose of improving patient care?**

**Information collected by your doctor will be used to provide you with quality patient care. Your personal health information will be kept confidential and will not be disclosed, unless required by law, to any third party without your consent whether verbally or in writing. I consent to the collection of medical information for the purpose of providing me with quality patient care. I am aware of my right to access information collected about me, except in some circumstances where access might be legitimately withheld. I understand I will be given explanation in these circumstance**

**Patient/Guardian Signature:                                                                                  Date:        /        /**

**You may have consistently consulted with a GP at another practice. The health information held by that GP may assist us with your future healthcare needs. You may wish to have a copy or summary of your health records transferred to this practice. Please ask your GP for information about how this can take place.**

**Previous GP details:**

**Doctors name/practice Name:**

**Address:**

**Phone: Fax:      Email:**

**OFFICE USE ONLY**

**Completed by: Pt file number: Date:**