Nillumbik and Research
Medical Centres

NEW PATIENT INFORMATION FORM

DO YOU REQUIRE A TRANSLATOR? YES ☐ NO ☐

TITLE: ______ FAMILY NAME: ________________________ GIVEN NAME: ___________________________________

DATE OF BIRTH: ____/______/________ Male ☐ Female ☐ TRANSGENDER ☐

STREET ADDRESS: ____ SUBURB: __________________________________

POSTCODE: _________ EMAIL: ____

HOME PHONE: _________________MOBILE PHONE: ___________________________WORK PHONE: ________________

DO YOU CONSIDER YOURSELF TO BE OF ABORIGINAL Or TORRES STRAIT ISLANDER ORIGIN? YES ☐ NO ☐

ETHNICITY: __________________________________

MEDICARE NUMBER: ☐☐☐☐ ☐☐☐☐☐ ☐ Reference Number: ☐

EXPIRY DATE: ______ / _______

DVA NUMBER: __________________________

EXPIRY DATE: ________ /_______

PENSION/HCC: ________________________________

EXPIRY DATE: _________ /________

EMERGENCY CONTACT: (used only in the event of an emergency)

NAME: ____ RELATIONSHIP: __________________________________

PHONE NUMBER: _______________________________

PRIVACY

Your private information is at all times treated confidentially with care and in accordance with the Australian Privacy Principles (APPs). A copy of our privacy policy is available on request.

I consent to receiving appointment reminders via SMS. YES ☐ NO ☐

I consent to receiving Recall Reminders via SMS. YES ☐ NO ☐

I understand it is my responsibility to ensure all personal contact details are updated with Nillumbik and Research Medical Centre staff.

Name/Guardian: ____ Date _________________________

Please turn over.

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Personal & Health Information Consent

We respect your rights to privacy and takes our privacy obligations seriously. We comply with the Australian Privacy Principles, found under the Privacy Act 1988 (Cth). Our Privacy Policy can be obtained from:

- www.nillmc.com.au
- Reception
- By calling (03) 9430 8888

We require your consent to collect personal information and health information about you. Please read this information carefully, and sign where indicated below.

Nillumbik and Research Medical Centre collects information from you for the primary purpose of providing you healthcare services. We require you to provide us with your personal and health information such as your medical history so that we may provide our services to you. We will also use the information you provide in the following ways:

- appropriately manage our practice, such as conducting audits and undertaking accreditation processes, manage billings and training staff;
- effectively communicate with third parties, including Medicare Australia, private health insurers, government departments and other practitioners involved in your healthcare.

I have read the information above and understand why my information is collected and how it is used. I acknowledge that I am not obliged to provide any information requested of me, but that failure to do so might compromise the quality of care provided to me.

Patient Name: ____

Date: _____/_____/_________

Patient signature: _____________________________________