NEW PATIENT INFORMATION FORM

SAHeart

PATIENT DETAILS

Title: _____ Given Names: _____ Surname: _____

Postal Address: _____

Suburb: _____ State: _____ Postcode: _____

Date of Birth: _____ / _____ / _____ Gender Male ○ Female ○ Unspecified ○ _____

Are you: Aboriginal ○ Torres Strait Islander ○ Aboriginal/Torres Strait Islander ○

Home Phone: _____ Mobile: _____

Email: _____

Allergies: Y ○ N ○ If yes, please specify: _____

MEDICARE / HEALTH INSURANCE INFORMATION

Medicare No.: _____ No. next to your name: _____ Expiry: _____ / _____

Veteran Affairs Card No.: _____ Type Gold ○ White ○ Expiry: _____ / _____

Pension No.: _____ Expiry: _____ / _____

Health Care Card No.: _____ Expiry: _____ / _____

Private Health Fund: _____ Membership No.: _____ Ref No.: _____

Hospital Cover Y ○ N ○

Is this visit in relation to a Work Cover/Insurance claim? Y ○ N ○

Occupation: _____ Company Name: _____

International Student Y ○ N ○ Country of Birth: _____ Cultural Background: _____

Do you require an interpreter or other communication service? Y ○ N ○ Please specify _____

GP Name: _____ Practice Name: _____

NEXT OF KIN DETAILS

Surname: _____ First Name: _____ Relationship: _____

Home Phone: _____ Mobile: _____

ACCOUNT PAYMENT RESPONSIBILTY

Please be advised that out-of-pocket costs may be incurred. It is SA Heart policy that full payment of your account is required on the day of service. For services covered by Medicare an online claim will be lodged. Eligible rebates will be paid directly into your bank account providing this is registered with Medicare. For services not covered by Medicare, full payment on the day of service is required. A collection fee may be charged for overdue accounts. I have read and agree with this statement:

Patient/Guardian Signature:_____ Date: _____ / _____ / _____

OFFICE USE ONLY **Patient ID #:** _____ **Registered by:** _____ **Date:** _____ / _____ / _____

Please note – this form is double sided, please turn over to complete

NEW PATIENT INFORMATION FORM

COLLECTION & DISCLOSURE OF PATIENT INFORMATION

The Privacy Act of 1988 requires all health practitioners to obtain consent from their patients to collect, use and disclose patients' information.

SA Heart collects your personal information and medical history for the purpose of providing quality cardiac care and so that we may properly assess, diagnose, treat and be proactive in your health care needs.

Disclosure and collection may also be required for administrative purposes in running our medical practice including Medicare, DVA, 3rd party transcription and non-medical information for debt collection if applicable.

For further information visit privacy.gov.au SA Heart's Privacy Policy is available at saheart.com.au

PATIENT CONSENT

- ○ I consent to the disclosure to and collection from medical/specialist practitioners, allied health practitioners, institutions and hospitals that may require information about my medical history in order to assess/treat the particular condition for which I have consulted the medical/specialist practitioner.
- ○ I consent to disclosure and collection that may also be required for administrative purposes as listed above.
- ○ In emergencies, I consent to SA Heart collecting information from my relatives or friends.
- ○ I am aware that this practice has a privacy policy on handling patient information.
- ○ I acknowledge that I have read this form and understand why collecting information about me is necessary. Before signing this form a member of this practice, at my request, has clarified any aspects as needed.

Patient/Guardian Signature: _____ Date: _____ / _____ / _____

AUTHORITY TO OBTAIN MEDICAL INFORMATION

I, _____

authorise the release of my health information as requested to SA Heart.

Patient/Guardian Signature: _____ Date: _____ / _____ / _____

Witness Signature: _____ Witness Name: _____

AUTHORITY TO RELEASE MEDICAL INFORMATION VIA EMAIL

I authorise SA Heart to release my medical information via electronic mail (email) to my email and/or the email of my family member/carer detailed in this document, and as necessary, any health practitioner involved in my treatment.

I am aware that SA Heart does not have encrypted email software and cannot guarantee that information transmitted via email will not be intercepted by other parties. By signing this form, I agree not to hold SA Heart or its employees responsible for any breach of confidentiality that may occur by someone else accessing the information contained in any emails sent to or from SA Heart regarding my personal health information.

I understand that reasonable means will be used to protect the security and confidentiality of the email. All concerns to and from me regarding my personal health information will be a part of my medical record and can be viewed by SA Heart doctors and support staff. My email will not be forwarded outside the office without my consent or as required by law.

This release may be revoked at any time by written notice and is valid until such revocation is received by SA Heart.

Patient/Guardian Signature:_____ Date: _____ / _____ / _____

OFFICE USE ONLY **Patient ID #:** _____ **Registered by:** _____ **Date:** _____ / _____ / _____