Talunga Clinic

New Patient Information Form

We are committed to providing our patients with the best care. To do this it is essential that your personal and medical records are to date and accurate.

Title	Mr/Mrs/Ms/Miss/Mast/Dr		Married/Single/Defacto/Divorced
Surname			
Given Names			Preferred name
Date of Birth	……/……/…….	Birth Sex	Male/Female
Gender Identity	Male/female/non binary/ Gender diverse/transgender Or Different identity	Pronouns	She/her/hers He/him/his They/them/theirs
Street address			
Postal Address			
Home Phone		Email	
Mobile		Work	
Medicare Number	_ _ _ _ _ _ _ _ _ _ _ _ _	PRN __	Expiry Date / /20
DVA Card	GOLD/WHITE - condition		Expiry Date / /20
Health Care Card		Expiry Date	
Pension Card		Expiry Date	
Next of Kin	Name	Relationship:	Contact number:
Emergency Contact	Name:	Relationship:	Contact number:
Prior Clinic Drs Name/Address			Transfer notes YES/NO

To assist with health initiatives are you Aboriginal/Torres Strait Islander. Yes/no

If No to above please state your ethnic origin _____

Country of Birth _____ Preferred Language Spoken _____

IT IS THE CLINIC'S POLICY FOR ALL ACCOUNTS TO BE PAID IN FULL AT THE TIME OF CONSULT ***PLEASE CANCEL ANY APPOINTMENT YOU CANNOT ATTEND - FAILURE TO DO THIS WILL INCUR A $50 FEE PER 15 MINUTE APPOINTMENT MISSED ***

Print Name _____Payer's Signature _____ Date_____

Personal Health Information Management

This PC → Company Data → Reception → Reception Master Copies → "New patient information"

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Updated 17.6.2025

To enable ongoing care and total quality improvement within this Practice, and in keeping with the Privacy Act 1988, we wish to provide you with information on how your Personal Health Information may be used, and record your consent or otherwise to this use. Your Personal Health Information will only be used for the purposes for which it was collected, or as otherwise permitted by law, and we respect your right to determine how your Personal Health Information is used or disclosed.

Personal Health Information may be collected in a number of different ways, such as notes from consultations, test results, Medicare and health insurance details, and details obtained from other health care providers (e.g. Specialists).

By signing below, you (as a patient, parent or guardian) are consenting that your Personal Health Information may be used or disclosed for the following purposes;

- Follow-up reminder / recall notices for treatment and preventative healthcare
- For accounting and the collection of professional fees
- The diagnosis and treatment of any health condition by professionally trained non-treating GPs and other qualified persons
- For legal disclosure as required by a court of law (e.g. court order, subpoena)
- For research purposes, only where de-identified information is used
- For training / teaching medical students and staff, using only de-identified information
- For disease notification when required by law (e.g. infectious diseases)
- When seeking treatment by other doctors in this Practice

At all times we are required to ensure that your details are treated with the utmost confidentiality and security. Your records are very important and we will take all steps necessary to ensure they remain confidential.

I, _____give my permission for my Personal Health Information to be collected, used and disclosed as described above. I understand that only my relevant Personal Health Information will be provided to allow the above actions to be undertaken, and I am free to withdraw, alter or restrict my consent at any time by notifying this Practice in writing.

Patient Name: (please print)_____

Parent/Guardian's Name, if applicable: (please print)_____

Relationship to Patient:_____

Signature: _____ Date: _____

PRACTICE USE ONLY… Witnessed by (Practice Staff Member)_____

M or F_____ Pension Status _____ IHI done _____

Ethnicity recorded in Demographics screen_____

New Patient Folder Given _____ MyMedicare registration _____

Updated 17.6.2025