GAWLER PLACE & UNIVERSITY HEALTH PRACTICES NEW PATIENT INFORMATION FORM

Surname/Family Name		First Name	
Date of Birth		Preferred Name	
Title (please circle)		If other (please specify)	
Street Address			
Suburb		Post Code	
Postal address (if different to above)			
Home Phone		Mobile		Work No.	
Email address			
Your Occupation		Your country of birth	
Do you wish to identify yourself as being:	Aboriginal Origin Yes No	Torres Strait Islander origin Yes No	
	Other cultural group (please specify)		
Is this a WorkCover/Third Party Claim?		Yes No	

*NB – if you have answered **Yes** to the above question, you will also need to complete the Return to Work SA/Third Party Information Form.*
Please ask our Receptionist for this form if needed.

*NB – International students should <u>**NOT**</u> answer the next block of Questions but should answer the relevant Questions overleaf*

Medicare Number:		Ref No		Expiry Date:	
DVA Card Number:		Colour of Card			
Pension/Healthcare Card Number:			Expiry Date:		
Do you have private health insurance?	Yes No		Membership Number: Private Health Insurance		
Level of Private Health Cover: (please circle one only)					

Next of Kin (ie your closest living blood relative)	Name	Relationship	Contact number
Emergency Contact (in Adelaide if possible) (if possible should be different to NOK)	Name	Relationship	Contact number

I understand that payment of all accounts is my responsibility. All accounts, other than accounts which are bulk billed to Medicare or which are billed to other Third Party payers, are payable in full at the time of treatment. For your convenience we can accept Cash, EFTPOS, Visa & MasterCard. I understand that in the event that accounts which are bulk billed to Medicare or which are billed to other Third Party payers are not honoured by such payers then payment of such accounts is my responsibility. I also undertake to pay any debt collection & legal costs that may be incurred by Adelaide Unicare as a result of late payment or non-payment of accounts.

Please tick to agree to the above:

If agreed to by a parent or guardian, please state name and address below:-

Parent/Guardian Name	
Parent/Guardian Address	

Please TURN OVER/CONTINUE to COMPLETE the next page

NEW PATIENT INFORMATION (continued)

IF YOU ARE A **TERTIARY STUDENT** (ie attending University, College, TAFE etc) PLEASE COMPLETE THE FOLLOWING		
Name of University/ or Institution	Student Number	Expiry Date

IF YOU ARE AN **OVERSEAS HEALTH COVER PATIENT**, PLEASE COMPLETE THE FOLLOWING		
Name of Fund ***(please circle as relevant)***	Membership Number	Expiry Date

IF YOU ARE A **UNIVERSITY OF ADELAIDE STAFF MEMBER** PLEASE COMPLETE THE FOLLOWING		
Name of school/section or department in which you work	Your staff ID number	Status

REMINDER SYSTEMS (to be completed by all patients)

Our Practice provides our patients with preventive care and early case detection reminders (eg immunisations, annual health checks, skin checks & pap smears). Reminders may be delivered by mail, phone or secure SMS.

Do you **consent** to participate in these Reminder Systems? Yes No *(NB we do not send "junk mail")*

How did you hear about the Practice?	

CONSENT FOR DE-IDENTIFIED DATA & PHOTOGRAPHY TO BE USED FOR TEACHING, TRAINING & RESEARCH

Adelaide Unicare is a 100% controlled entity of the University of Adelaide. From time to time University educators & researchers may wish to access your de-identified medical records & medical photographs for teaching, training & research purposes. If however any of your private details are to be disclosed then your further consent will be obtained.

I have read, understood and agree to the above and consent to my de-identified medical records & medical photography being used in the manner described, subject to any limitations on access or disclosure about which I notify this Practice now or at any time in the future.

Please tick if you agree:

PATIENT PRIVACY

If we need to contact you by phone, may we leave a message or send a SMS to your mobile?
Your permission is required to protect your privacy. Please tick as applicable. **Yes** **No**

The personal health information that you provide during your consultation and subsequent treatment will be used for the purposes of providing you with high quality health care. Our policy is to protect your privacy and accordingly the information you provide will only be disclosed to other members of your medical treatment team where necessary. It will also be disclosed to other organisations where required by law or where required for billing or debt recovery purposes.
A copy of our full Patient Privacy Policy is available on our website at www.adelaideunicare.com.au. If you have any concerns about the way we manage your health information please let us know. In the first instance this can be done by contacting the Practice Manager or your doctor. Alternatively we have a suggestion box in the patient waiting area. If you are still dissatisfied, you can contact the Federal Privacy Commissioner at:-

Office of the Australian Information Commissioner (OAIC), GPO Box 5218, Sydney NSW 2001
Website: www.oaic.gov.au Privacy hotline: 1300 363 922

I have read and understood, and agree to the above and consent to my health information being collected by the Practice.

Please Tick to Agree:

Although we are very careful with your personal information, we cannot guarantee its privacy when emailed. If you prefer you can print this form and bring it to your next visit.

If the submit button is not allowed please save and email this form as an attachment to **uhgawler@adelaide.edu.au**