NEW PATIENT DETAILS FORM

TOOWOOMBA MEDICAL CENTRE

Date of Initial Consultation _____/_____/_____

Welcome to our practice. To enable us to provide you with the best care please complete our health questionnaire.
This information is strictly confidential, and every question is important!

Title: Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Master ☐ Doctor ☐
Last Name: _____ ***Given Names:*** _____
Date of Birth: _____/_____/_____
Gender: _____
Nationality: _____
Marital Status: _____
What was your sex recorded at birth (Please Circle) – Male / Female
How do you describe your gender – Male or man / Female or Woman / Non-binary / Transgender / Gender Diverse / Prefer not to say
Marital status - Single / Married / De facto / Separated / Divorced / Widowed
Living Arrangement: Accommodation / Own Home / Rental / Age Care / Relative Home **Living with:** Partner / Relative / Alone / Other

Street Address: _____
Suburb: _____ ***Post Code:*** ___ ___ ___ ___
Home Phone No: _____ **Work Phone No:** _____ ***Mobile No:*** _____
Email: _____ **Occupation:** _____

What is your cultural background? _____
Country *of Birth:* _____
Are you of Aboriginal or Torres Strait Islander origin?
No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Both, Aboriginal and Torres Strait Islander ☐
If yes, are you registered with the Closing the Gap program? Yes ☐ No ☐
Is English your first language? Yes ☐ No☐ ***If English is not your first language, do you require an interpreter?*** Yes ☐ No ☐
What is your preferred language for an interpreter? _____

Medicare Card No: ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ***Ref.*** ____ ***Expiry Date*:** _____
Health Care Card? ☐ **or *Pensioner Concession Card?*** ☐
Card number: _____ ***Card Expiry Date:*** _____
Private Health Insurance Fund _____ **Member No:** _____ **Ref:** _____
DVA Card No: _____ ***Expiry Date*:** _____ **Gold** **White**
Are you registered with a MyHealth Record? Yes ☐ No ☐

Next of Kin _____ ***Emergency Contact*** _____
Relationship _____ ***Relationship*** _____
***Phone* No** _____ ***Phone* No** _____

Allergies
Do you have any allergies? E.g. food, medication, type of dressings? ☐ ***Yes (Please Specify)*** ☐ ***No***
Allergen ***Reaction*** ***Severity***
_____

Smoking ☐ ***Never*** ☐ ***Current*** ☐ ***Ex-Smoker***
Alcohol ☐ ***Number of days per week*** ☐ ***Number of drinks per day*** ☐ ***Non-drinker***

Use of artificial intelligence (AI) for documentation

Our doctors may use secure AI technology to assist with preparing your clinical notes and letters. This technology can listen to the consultation and create a draft note, which your doctor reviews, edits and approves. The AI system does not make diagnoses or treatment decisions and your doctor remains responsible for your care and for the accuracy of your record. We will always explain this to you and ask for your permission before using AI in your consultation. You can choose not to use AI, or change your mind at any time, and this will not affect the care you receive.

CONSENT FORM – PRIVACY AND COMMUNICATION

Our practice collects, uses, and securely stores your personal and health information to provide quality healthcare. This includes details such as your name, contact information, medical history, Medicare details, and other relevant data.
We may share your information when:

- Required by law or public health requirements.
- Necessary for your treatment (e.g., with other healthcare providers).
- Assisting with medical services like My Health Record.
- Supporting practice operations, such as accreditation or IT services (bound by privacy standards).

You may choose to remain anonymous or use a pseudonym unless it is impractical or legally required for identification.
You have the right to access, update, or correct your information. Requests can be made in writing to: practicemanager@toowoombamedicalcentre.com.au.

COMMUNICATION PREFERENCES

This practice has implemented technology solutions to enable communication with our patients via SMS using third-party providers. With your consent, we may disclose your personal information (including health information) to send appointment and clinical reminders, clinical communications, and health awareness notifications.

Please choose your all your preferred contact methods:
☐ Phone ☐ Letter ☐ SMS ☐ Please do not contact me using any method

AUTHORISED COMMUNICATION

If there are other individuals authorised to communicate on your behalf, please list them below:

Name: _____ **Relationship:** _____**Phone:**_____
Name: _____ **Relationship:** _____**Phone:**_____

Consent
By signing below, I confirm:

1. I have read and understood the practice's privacy and communication policy
2. I understand this consent form complies with the RACGP 5th Edition Standards and Australian Privacy Principles.
3. I have read and understood how my personal and health information will be collected, used, stored, and shared.
4. I have selected my preferred communication methods and may update these preferences in the future.
5. I consent to the collection, use, and sharing of my information as outlined, including sharing with third-party providers where necessary, with additional consent sought for any other purposes.
6. I understand that some third-party providers may receive my personal information to facilitate communication.
7. I understand that failure to provide consent or required information may limit the services the practice can provide.

Patient's Full Name: _____

Signature: _____
Date: _____