

**UNIVERSITY HEALTH PRACTICE
NEW PATIENT INFORMATION FORM**



Surname/Family Name		First Name & other initials	
Date of Birth/...../..... day month year	Preferred Name	Sex (M/F)
Title (please circle)	Mr Mrs Mast Miss Dr Ms	Preferred pronoun	Other (please specify)
Street Address			
Suburb		Post code	
Postal address (if different to above)			
Home Phone		Mobile Phone	Work Phone
Email address <i>please print clearly</i>			
Your Occupation		Your country of birth	
Do you wish to identify yourself as being:	Aboriginal origin	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Torres Strait Islander origin	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Other cultural group (please specify)	
Is this a WorkCover/Third Party Claim? <i>Please circle as applicable</i>			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.			

NB – International students should NOT answer the next block of Questions but should answer the relevant Questions overleaf

Medicare No.	Ref No (ie the number next to your name)	Expiry date
DVA Card No.	Colour of Card	
Pension/Healthcare Card No.	Expiry Date	
Do you have private health insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Private health insurance membership No.
Level of private health cover (please circle one only)	Hospital and Extras	Hospital only Extras 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.

Signed	Date
<i>If signed by parent or guardian, please state name and address below:-</i>	
Parent/Guardian Name	
Parent/Guardian Address	

CONTINUED OVERLEAF

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

(NB not required if you are covered by Medicare)

Name of Fund (<i>please circle as relevant</i>)	Membership Number	Expiry Date
Allianz OSHC / Medibank / AHM / BUPA / NIB		
Other – <i>please specify</i>		

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 (ie FT; PT; or casual)

REMINDER SYSTEMS (to be completed by all patients)

Do you agree to receive a reminder for ongoing preventative healthcare (eg skin checks)? Yes No

Reminders may be delivered by mail, phone or secure SMS.
NB we do not send "junk mail".

How did you hear about Practice?	<input type="checkbox"/> Internet	<input type="checkbox"/> Family/friend	<input type="checkbox"/> Student
	<input type="checkbox"/> Promotion (please specify).....	<input type="checkbox"/> Other (please specify).....	

CONSENTS & PATIENT PRIVACY

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. *De-identified* data is also sent to the local Primary Health Network as part of identifying quality improvement measures.

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 note – if any of your private details are to be disclosed then your further consent will be obtained

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

If we need to contact you by phone, may we leave a message or send a SMS to your mobile? Yes No

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

Signed		Date	
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Please don't forget to also sign and date this page