New Client Information Form

—COASTAL—
skin & laser

Could you please assist us by completing the following:		
☐ Dr ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Mast	**Birth Sex:** ☐ M ☐ F	**Gender Identity:**
Pronouns ☐ She/Her/Hers ☐ He/Him/His ☐ They/Them/Theirs	**Surname**	
First Name	**Middle Name**	
Preferred Name	**Date of Birth**	
Occupation		

Street Address		
Suburb	**Post Code**	**State**
Home Phone	**Mobile Phone**	
Work Phone	**Email**	
Do you give your consent to receive recall and reminder services via SMS?	☐ Yes ☐ No	
How did you hear about us?		

Medicare Number & Ref #:	Line #:	Expiry:
☐ **DVA Gold** ☐ **DVA White** (Please tick)	**#:**	Expiry:
Pension Number ☐ **Health Care Card No.** ☐ (Please tick)	**#:**	Expiry:
Private Health Fund **Yes** ☐	**No** ☐	
Name of Private Health Fund provider		

Name & Relationship of Next of Kin (Name and Telephone number)	Date of birth of NOK (if patient is a child):
Emergency Contact (Name and Telephone number of the person we can contact if needed)	

DO YOU HAVE ANY ALLERGIES OR ARE YOU SENSITIVE TO DRUGS OR DRESSINGS?	
☐ No	☐ Yes. Please elaborate:

Patient Background

Do you identify as someone from a culturally and/or linguistic diverse background?	
☐ No	☐ Yes. Please elaborate:

To assist with health initiatives – are you an Aboriginal or Torres Strait Islander?			
☐ No	☐ Yes - Aboriginal	☐ Yes - Torres Strait Islander	☐ Yes - Aboriginal & Torres Strait Islander

Your Privacy is our concern

Coastal Skin & Laser collects information from you for the primary purpose of providing quality health care, in keeping with the *Privacy Act 1988* and *Australian Privacy Principles*. Your personal information will only be used for the purpose for which it was collected or as otherwise permitted by law and we respect your right to determine how your information is used and disclosed. Information we collect may include: medical test results, consultation notes, Medicare details and specialist correspondence.

By signing below you are consenting to the collection of your personal information, and that it may be used or disclosed by the practice for the following purposes: administration, billing, recall reminders (via SMS, telephone and mail), disclosure to others involved in your health care, medical teaching & research (de-identified data) & to comply with any legislative requirements (eg. notifiable diseases). At all times, we are required to ensure your details are treated with the utmost confidentiality.

Test Results

It is the policy of this surgery not to inform you of any pathology or specific test results over the phone for privacy reasons. We will advise you if you need to make an appointment to discuss results of any recent tests you have had done if the GP requests this. Otherwise if you have been actively encouraged to review any tests the GP has asked you to undertake please make a follow up appointment.

Please be aware that we will not give your test results to a third party for privacy reasons, except for exceptional circumstances.

Health Information

We encourage our patients to be pro-active in their health care and to help with this we will from time to time send you information regarding any health initiatives we feel you may benefit from. If you do not wish to receive this information, please advise the reception staff.

I,…… have read and agree to all of the above.

Signature…….. Date……

If not patient signing – Your name…….....

Your relationship to patient……..