

## New Patient Information Form

Surname	First Name	DOB ___/___/___
Address		Postcode
Phone	Mobile	
Email (our preferred method of contact)		
Health Fund	Occupation	

<b>How did you find out about our services?</b> (tick all that apply and <b>circle</b> the source that made the decision for you)			
Word of Mouth	<b>Internet Search</b>		
Yellow Pages	Google	Yellow Pages Online	
Newspaper	Yahoo	Hotfrog	
Health professional referral	Start Local	Squidoo	
Other	Natural Therapy Pages	Other	

<p><b>For Your Comfort.</b> It is very important to us that we provide the very best of treatment. If there is anything that you would like to tell us, that would make your visit the best it could be, please let us know - we will listen.</p>

<b>Medical History.</b> (list any operations, accidents and serious illnesses you have had or currently have)	
Operations	
Surgery	
Accidents	
Illnesses/Ongoing complaints	

<b>Medications and Supplements</b> (you are currently taking or have taken in the last 6 months)	
Prescribed medicines	
Non prescribed medicines	
Vitamins & other supplements	

<b>Other Healthcare Practitioners</b> (GP, Physiotherapist, Chiropractor, osteopath, Naturopath, Masseur, etc,)	
<b>Name</b>	<b>Address &amp; Phone Number (if known)</b>

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**Presenting Complaint** (briefly describe your reason(s) for consulting me today)

### Clinic Email Newsletter

We send out a regular informational email newsletter. Would you like to be included on our mailing list? **Note:** if you tick yes you can always opt out at any time in the future. **YES / NO** (circle your choice)

### Your Health Information and Our Privacy Policy (in Accordance with the Victorian Health Records Act 2001 and The Privacy Act)

Our Practice respects your right to privacy. We realise that it is important that you understand the purpose for which we collect details about your health, as well as how this information is used at our practice, and to whom this information might be disclosed.

*The Policy of our Practice is to follow these procedures:*

1. The information collected will be used for the purpose of providing treatment for you. Personal information such as your name, address and health insurance details will be used for the purpose of processing your account payments and writing (includes emailing for those who provide us with an email address) to you about our services and any issues affecting your treatment.
2. As a matter of courtesy we inform (in writing) your General (medical) Practitioner that we are treating you, unless you specifically request we do not do so. We will not provide any details (at all) of the treatment, except where it is deemed necessary (see point 3 below).
3. We may disclose your information to other health care professionals, or require it from them, if, in our judgement, that is necessary in the context of your treatment. In that event, disclosure of your personal details will be minimised wherever possible and only given, or requested, with your consent (verbal unless you specifically request that it be in writing).
4. We may also use parts of your health information for research purposes, in study groups or at seminars, as this may provide benefit to other patients. Should that happen your personal identify will not be disclosed without your consent.
5. If any of the information we have about you is inaccurate, you may ask us to alter our records accordingly.

You can otherwise be assured that your health information will be treated with the utmost confidentiality. Disclosure will not be made to any person not involved in either your treatment or the administration of this practice, without your prior written consent. If you have any questions or concerns about our handling of your health information, please raise them with our practice.

Otherwise please sign this form as confirmation that you have read and understood our privacy policy, and consent to the use of your information in this way.

**By signing this form you also agree to our payment policy, which is: payment in full is required at the time of your treatment.**

Signed \_\_\_\_\_

Date \_\_\_\_ / \_\_\_\_ / 2009

Parent/Guardian<sup>1</sup> (Name & Relationship to patient) \_\_\_\_\_

Signed \_\_\_\_\_

Date \_\_\_\_ / \_\_\_\_ / 2009

<sup>1</sup> If the patient is under the age of 16 the parent/legal guardian is required to sign this form.