McKinnon Hill Medical Centre

New Patient Information Form

Personal, contact and communication details

We collect this information to provide safe, high-quality, culturally appropriate healthcare and to meet our legal and accreditation requirements. Your information is handled securely in accordance with Australian privacy laws and our Privacy Policy. If you need assistance completing this form, please ask our reception team.

1. About you

Title | **Surname / family name** | **First name(s)**

Date of birth (DD/MM/YYYY) | **Preferred name** | **Pronouns**

Sex recorded at birth *This information may be important for safe and appropriate medical care.*

☐ Male ☐ Female ☐ Another term: ☐ Prefer not to say

Gender

☐ Woman ☐ Man ☐ Non-binary ☐ Another term: ☐ Prefer not to say

Residential address

Suburb | **State** | **Postcode**

Mobile | **Other phone** | **Email**

Communication preferences

Appointment reminders ☐ SMS ☐ Phone ☐ May leave voicemail

Health recalls ☐ SMS ☐ Phone

2. Medicare and concession details

Medicare number | **Ref.** | **Expiry**

Pension / Health Care Card number | **Expiry** | **DVA file number**

3. Emergency contact and next of kin

Emergency contact

Full name | **Relationship**

Mobile | **Other phone**

Next of kin ☐ Same as emergency contact

Full name | **Relationship**

Mobile | **Other phone**

An emergency contact or next of kin is not automatically authorised to receive your medical information.

4. Cultural background and communication needs

The following information helps us provide safe, respectful and personalised healthcare. You may choose not to answer some of these questions.

Are you of Aboriginal and/or Torres Strait Islander origin?

☐ No ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Prefer not to answer

Country of birth | **Cultural background / ethnicity**

Preferred language | **Religion or spiritual considerations**

Interpreter, Auslan interpreter or other communication support required?

☐ No ☐ Yes - Please specify language:

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Health information, privacy, fees and acknowledgement

Patient name

Date of birth

5. Health information

Allergies and adverse reactions

☐ No known allergies

Medication, food, latex or other substance	Reaction / symptoms

Current medications, vitamins and supplements

Name	Strength	Dose / how often

Usual pharmacy (name and suburb)

Current health conditions

Past significant health problems / surgery

6. Lifestyle, family history and previous GP

Smoking / vaping

☐ Never ☐ Former ☐ Current ☐ Vapes

Alcohol

☐ None ☐ Yes

Days per week

Drinks per day

Significant family history

Health condition	Family member affected

Previous GP or medical practice

Suburb

Would you like us to help transfer your medical records from your previous clinic? ☐ Yes ☐ No

7. Privacy and AI documentation

We collect personal and health information to provide care, manage your record and meet legal and administrative requirements. Information may be shared with providers involved in your care and with organisations such as Medicare where permitted or required. Our Privacy Policy explains access, correction, complaints and security and is available at reception and on our website.

☐ I acknowledge the Privacy Collection Notice.

AI-assisted notes:
A practitioner may ask to use an AI documentation tool. Consent will be requested at the start of that consultation. You may decline without affecting your care.

8. Billing and fees

McKinnon Hill Medical Centre is a mixed-billing and cashless practice.

Fees are payable in full on the day of your consultation by electronic payment.

Medicare rebates are processed where eligible. Fees may vary with consultation length, complexity and additional services. Bulk billing applies only to eligible appointments and patient groups. After-hours, weekend and public holiday appointments, procedures, consumables, reports, forms, cancellations, non-attendance and overdue accounts may attract fees. Please ask reception about expected fees before treatment.

☐ I acknowledge the Practice Fee Policy and fee schedule.

9. Consent and acknowledgement

Patient / parent / guardian full name

Relationship (if applicable)

How did you hear about us? (optional)

Signature

Date