all in one health

New patient form

Name: Mr/ Mrs/ Ms/ Dr/ Miss / Mast:

First name: _____ Last name: _____

Address:_____

Suburb: _____Postcode:_____

Date of Birth: _____ / _____ / _____ Sex: Male/Female

Phone: (H) _____ (M) _____

Email:_____

Private Insurance: Yes/No: Who is your private health with? _____

Occupation:_____

Medicare card number: _____ Reference number: _____

Work cover claim number: _____ Case Manager details: _____

In case of emergency, Notify: _____Telephone: _____

GP's name: _____Do you consent to us contacting your GP? Yes /No

How did you hear about us?:_____

Reason For visit?

_____

Allergies:

_____

Current Medication (prescriptions, over-the-counter and Vitamins):

_____

Family history:

_____

Your Medical History -please circle if you have any of the following

Vision issues	Heart Disease	Hearing issues	Circulation issues	Thryiod issues	Osteo - arthritis
Asthma	Hypertension	Angina	Rheumatoid	Cancer	AID/HIV
Epilepsy	Surgeries	Diabetes	Other:		

PRIVACY CONSENT

There is now a legal requirement that we gain your consent to collect and use personal information about you. Please read the following carefully and sign the declaration if you consent to All in one Health collecting this information.

In order to properly assess, diagnose and treat you, All in one Health needs to collect some personal and medical information from you. This information may also be used for:

- The administrative purposes of running the practice.
- Billing, either directly or through a third party.
- Use within the organisation, when passing information to other clinical staff for your ongoing treatment and care.
- Disclosure of treatment and medical information to your other clinical treatment providers. In the case of an insurance or compensation claim, it may be necessary to collect and/or disclose information that affects your treatment and return to work. The provision of your high quality treatment may require the sharing of information about your condition, treatment and in some cases third-party claim status may be shared with other treatment providers, insurers, solicitors and employers. DECLARATION I have read the above information and understand the reasons for collecting information and the ways in which this information might be used. I understand that it is my choice what information I provide but that withholding or falsifying information might be detrimental to my treatment. I consent to allow All in one Health to collect further information related to my treatment, from other sources as necessary, including x-ray reports, medical reports etc. I am aware that I can access my personal and treatment information on request and, if necessary, correct information I believe to be inaccurate. I understand that if, in exceptional circumstances, access is denied for legitimate purposes that the reasons for this and possible remedies will be made available to me. I understand that All in one Health must obtain additional consent if the information collected is to be used in ways other than those described above.
- **I understand that I am financially responsible for any balance due on my account whether privately paying or should medicare, DVA or workcover decline my visit.**

Date: / / Signed: .....