New Patient Information Form

SIGNAL HEALTH NEWTON

Please complete this form if you are a new patient to Signal Health Newton. If you need any help, our team will be happy to assist you.

Instructions:

1. Please complete all required fields (marked with an asterisk*).
2. Please tick (✔) or mark (✘) in the ◯ for multiple-choice questions.

Patient Details

First name* _____ **Last name*** _____

Preferred name _____ **Date of birth*** _____ /_____ /_____

Birth sex (required for Medicare)* ◯ Female ◯ Male ◯ Other

Email* _____

Mobile* _____ **Home phone** _____

Address* _____

Suburb* _____ **Post code*** _____ **State*** _____

What is your country of birth? _____

Do you identify as Aboriginal or Torres Strait Islander?*

◯ Aboriginal ◯ Torres Strait Islander ◯ Both ◯ No

Emergency Contact

First name* _____ **Last name*** _____

Contact number* _____ **Relationship to you*** _____

Next of Kin

◯ **Tick if same as Emergency Contact or complete below**

First name _____ **Last name** _____

Contact number _____ **Relationship to you** _____

Card Details

Do you have a Medicare Card?* ◯ Yes ◯ No *If yes, please provide your details:*

Card number* _____ **Reference No.*** _____ **Expiry date*** ____ / ____

Do you have a Concession Card? ◯ Yes ◯ No *If yes, please provide your details:*

Card Type: ◯ Aged Pension Card ◯ Health Care Card ◯ Disability Pension Card ◯ Carer Pension Card ◯ Newstart

Card number _____ **Expiry date** _____ / _____

Do you have a DVA Card? ◯ Yes ◯ No *If yes, please provide your details:*

Card number _____ **Expiry date** _____ / _____

Claims

Do you have a current WorkCover or Motor Vehicle Accident Claim?*

◯ Yes ◯ No *If yes, please provide details below:*

Claim Number: _____ **Date** _____ /_____ /_____

Details: _____

Account Details

Will you be managing your own accounts with us?*

◯ Yes ◯ No *If no, please provide the name and contact details of the person responsible for managing your accounts below:*

First name* _____ **Last name*** _____

Preferred name _____ **Date of birth*** _____ /_____ /_____

Address* _____

Medicare Card number* _____ **Reference No.*** _____ **Expiry date*** ____ / ____

Contact number _____ **Relationship to you** _____

Communication Consent

Your doctor or our team at Signal Health Newton may contact you via SMS and/or email with important healthcare information, including:

- Appointment reminders
- Clinical information (e.g., test results or follow-up instructions)
- Health reminders from your doctor (e.g., routine screenings, vaccinations, or chronic disease management)

If you choose to opt out of these communications, you will not receive appointment reminders, test result notifications, or health reminders from your doctor or our team via SMS or email.

You can update or revoke your consent at any time by notifying our admin team.

I consent to receiving SMS reminders, messages, and emails as described above* ◯ Yes ◯ No

Would you like us to register your provided email for our website to receive emails about our practice news and updates?* ◯ Yes ◯ No

Authorised Contact/s for Clinical Information

We are committed to protecting the confidentiality and privacy of your personal health information. In accordance with our privacy policies and relevant regulations, we will only disclose your clinical information directly to you or to another healthcare provider who is involved in your care (such as a specialist to whom you have been referred).

If you would like to authorise a specific family member or contact person to receive and discuss your clinical information on your behalf - including appointment details, pathology, radiology, or other test results - please authorise the below. Please note that if you don't provide this authorisation, we will be unable to share your personal health information with anyone else, including family members or friends, unless we receive your consent at a later time.

Would you like to authorise a family member or contact person to discuss your clinical information?*

◯ Yes ◯ No *If yes, please provide details below (you can fill out 1, 2 or 3 authorised contacts):*

Authorised Contact 1: Name _____

Contact number _____ **Relationship to you** _____

Authorised Contact 2: Name _____

Contact number _____ **Relationship to you** _____

Authorised Contact 3: Name _____

Contact number _____ **Relationship to you** _____

MyMedicare Registration

MyMedicare is a free, voluntary program that strengthens your connection with your usual GP and practice. Registering helps ensure better continuity of care, access to new benefits, and more personalised support for your health.

By signing this form, I confirm that:

- I understand MyMedicare registration is voluntary and free.
- I consider this practice to be my regular provider.
- I can only be registered with one practice at a time. Registering here will replace any previous registration.
- I will remain registered unless I change practices or ask to withdraw.
- I have read and understood the MyMedicare Privacy Notice and consent to the use of my personal information as outlined (available on the Department of Health and Aged Care's website).

For patients under 14, a parent or legal guardian must provide consent. For patients aged 14–17, the patient must consent. A parent or guardian can complete the form if the patient agrees and understands. If a patient 14 or older is unable to consent, an authorised representative may do so on their behalf.

Would you like to register for MyMedicare to access new healthcare benefits?*

◯ Yes ◯ No *If yes, please select your preferred GP below*

Select the name of your preferred GP for MyMedicare (only one can be chosen):*

◯ Dr. Joe Alvaro ◯ Dr. Simon Hayward ◯ Dr. Andrew Kellie

◯ Dr. Maria Sauchelli ◯ Dr. Ellen Stamati ◯ Dr. Michael Menezes

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Clinical Information

If you are unable to obtain a medical summary from your previous practice, please complete the information below as accurately as you can.

Past Conditions/Operations/Accidents:

_____ **Year:** _____

_____ **Year:** _____

_____ **Year:** _____

_____ **Year:** _____

_____ **Year:** _____

Disabilities: _____ **Year:** _____

Other medical practitioners / specialists you are seeing: _____

Family History (for example, high blood pressure, cancer, diabetes etc):

Mother: _____ Siblings: _____

Father: _____ Other: _____

Current medications (including over the counter medications/vitamins):

_____

_____

_____

_____

Allergies (food, medications etc):

_____

_____

Smoker: ◯ Yes ◯ No **Ex-Smoker**: ◯ Yes ◯ No Year Started: _____ Year Stopped _____

Alcohol: Number of standard drinks per day: _____ Per week: _____

Have you had the following immunisations (please complete below):

Flu: ◯ Yes ◯ No ◯ Unsure Date: _____ COVID-19: ◯ Yes ◯ No ◯ Unsure Date: _____

Tetanus: ◯ Yes ◯ No ◯ Unsure Date: _____

Have you had the following checks or screenings (please complete below):

Cholesterol: ◯ Yes ◯ No ◯ Unsure Date: _____ Prostate: ◯ Yes ◯ No ◯ Unsure Date: _____

Blood Pressure: ◯ Yes ◯ No ◯ Unsure Date: _____ Skin: ◯ Yes ◯ No ◯ Unsure Date: _____

Cervical Screening: ◯ Yes ◯ No ◯ Unsure Date: _____

Bowel Cancer Screening: ◯ Yes ◯ No ◯ Unsure Date: _____

Do you have an Advanced Care Directive? ◯ Yes ◯ No ◯ Unsure

Who is completing this form?*

I understand that Signal Health Newton is a private billing practice. Bulk billing is not routinely available, and an account will be issued for each consultation. I have read and accept the fee policy outlined above.

◯ I am the patient ◯ I am the patient's parent, legal guardian or substitute decision-maker

Full Name: _____

Signature: _____ **Date:** _____ /_____ /_____

How did you hear about our practice?

◯ Family ◯ Friend ◯ Google / Online Search ◯ Our Website ◯ Social Media

◯ Other: _____

Thank you for taking the time to complete this form.
We look forward to supporting your health journey at Signal Health Newton.