# New Patient Information Form

SIGNAL HEALTH

Please complete this form if you are a new patient to Signal Health. 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.

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## 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

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## Emergency Contact

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

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

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## Next of Kin

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

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

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

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## 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** _____ / _____

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## Claims

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

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

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

**Details:** _____

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## 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** _____

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## Communication Consent

Your doctor or our team at Signal Health Tusmore 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** _____

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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:** _____

**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

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## Privacy Consent and Collection of Personal Information

By registering as a patient of Signal Health, you acknowledge that you have read, understood, or had the opportunity to review our Privacy Policy, available on our website and at reception, and consent to the collection, use, storage, and disclosure of your personal information (including health information) as reasonably necessary to provide your healthcare, manage appointments, process claims, coordinate your care, communicate with you, and operate our practice. This may include the use of secure technology systems and carefully selected digital or AI-assisted tools for administrative or clinical support (such as appointment handling, document processing, and note drafting), with appropriate safeguards and clinician oversight where relevant. Where additional consent is required for specific activities, such as certain recordings, we will seek this separately. We do not sell your personal information. You may request access to or correction of your information in accordance with our Privacy Policy.

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## Who is completing this form?*

I understand that Signal Health Tusmore 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 information 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.**