韦弗利家庭医疗保健 Waverley Family Healthcare
維夫利 58 Pinewood Drive
Mount Waverley, 3149 Vic

新病人表格

(NEW PATIENT FORM)

为了使您能获得良好的医疗保健，请完整详细的填写这份病历表。如果您不方便填写或有任何不确定的地方，请随时向我们的医生咨询。因您通过这份表格向我们提供了您的健康状况信息，请您仔细阅读并签署随附的 “健康信息收集和使用知情同意书”，以便我们为您医疗服务时可以使用这些信息。

(This complete medical history is important for you to obtain good health care. Please feel free to discuss with the doctor if you are unsure of anything or cannot write it down. As you are providing us with health information please also read and sign a consent form to allow us to collect and use your health information.)

请用正楷字体填写，如需帮助，请告知我们。

(Please ask for assistance if you need help writing in English, please use block letters.)

个人资料 (Personal Details)

称谓 (Title) 先生(Mr)/女士(Mrs)/夫人(Miss)/小姐(Ms)_____

名：(First Name)_____

姓：(Surname)_____ 出生日期：(DOB)_____ / _____ / _____

性别：男(Male)/女(Female)/双性人(Intersex)/其他(Other)

国民保健卡号(Medicare No).:_ _ _ _ _ _ _ _ _ _ _ _ _ 编号：(Ref)_____ 有效期：(Expiry)____/____

土著居民/托雷斯海峡岛民：(Aboriginal/Torres Strait Islander) 是(Yes)/否(No)

国籍：(Ethnicity) _____ 出生国：(Country of Birth)_____

地址：(Address)_____

区：(Suburb)_____ 邮编：(Postcode)_____

手机号码：(Mobile)_____ 家庭电话:(Home no)_____

工作电话：(Work)_____ 邮件:(E-Mail)_____

养老金号:(Pension No)_____ 有效期：(Expiry)_ _ /_ _/_ _

健康卡/退伍军人卡/优惠卡：(HCC/DVA/Concession)_ _ _ _ _ _ _ _ _ _ _ _ 有效期：(Expiry)__/ __ /__

婚姻状态（请画圈）：单身(Single)，已婚(Married)，订婚(Engaged)，离婚(Divorced)，事实婚姻(De Facto) 同居伴侣 (Have a Partner)，丧偶(Widowed)，其他：(Other)_____

紧急联系人姓名：(Emergency Contact Name)_____

紧急联系人电话：(Emergency Contact Number)_____

与紧急联系人关系：(Emergency Contact Relationship)_____

宗教信仰：(Religion)_____ 职业：(Occupation)_____

首选语言：(Preferred Language)_____

特殊需求：(Special Needs)_____

健康信息收集和使用知情同意书
Health Information Collection and Use Consent Form

As a patient of our medical practice we require you to provide us with your personal details and a full medical history, so that we may properly assess, diagnose, treat and be proactive in your health care needs. We aim to protect the privacy and secure storage of your health information. You can request a copy of our privacy policy, which includes information about the collection, use and disclosure of your health information. We require your consent to collect personal information about you and to use the information you provide in the following ways. Please read this consent form carefully, and sign where indicated below.

作为我们的医疗服务病人，我们需要您的详细个人信息和完整的病历，以便我们能对您的病情进行正确的评估、诊断、治疗并对您的健康需求采取积极有效的措施。我们注重对您的隐私的保护及您的健康信息的安全保存，您可以要求我们提供一份关于您的健康信息的收集、使用及泄露的隐私保护原则的副本。我们需要您的书面同意来收集您的个人信息，并通过以下方式使用您所提供的信息。请仔细阅读本同意书，并在下面所要求的地方签字。

Administrative purposes in running our medical practice.

出于本医疗保健管理运营的目的。

Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.

费用处理的目的，包括依照公共医疗和健康保险委员会的要求进行的处理。

Disclosure to others involved in your healthcare including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following referrals.

把您推荐给医疗保健方面相关的本医疗保健处外的医生和专家。这种情况包括把您推荐给其它的医生时，在所推荐的医生处做医疗测试时，及我们收到您在被推荐医生处所做的测试的医疗报告和结果时。

Disclosure to other doctors in the practice, locums etc. attached to the practice for the purpose of patient care and teaching.

把您的信息透露给其它的在职医生及以照顾和教导病人为目的从属代理医生。

For research and quality assurance activities to improve individual and community health care and practice management. Usually information that does not identify you is used but should information that will identify you be required you will be informed and given the opportunity to “opt out” of any involvement.

为了提高个人和社区健康护理和实践管理的研究和质量保证的活动。在这种情况下所使用的您的信息是不会使您的身份被识别的。如需要用到您会被识别的信息，您会在信息被使用前得到通知并且您有机会选择“决定退出” 任何的相关事项。

To comply with any legislative or regulatory requirements eg notifiable diseases.

遵照法律或规定的要求，比如：法定传染病。

For reminder letters which may be sent to you regarding your health care and management.

需要向您发送关于您健康护理和管理的提醒信件时。

You can decline to have your health information used in all or some of the ways outlined above but it may influence our ability to manage your health care to provide the best outcome for you.

您可以拒绝您的健康信息被以上所列出的全部或部分方式使用，但这会影响我们为您提供最符合您利益的健康医疗护理管理。

健康信息收集和使用知情同意书
Health Information Collection and Use Consent Form

我已阅读了上述信息，并已理解收集我的信息的原因。 (I have read the information above and understand the reasons why my information must be collected.)	
我明白我没有义务提供我的信息，但如果不提供相应信息，我所接受的保健和治疗的质量就会受到影响。 (I understand that I am not obliged to provide any information requested of me, but failure to do so may compromise the quality of health care and treatment given to me.)	
我知道我有权了解所有被收集的有关我的信息，除了一些法律规定的特别情况，但在这些情况下，我会得到相应的解释说明。(I am aware of my rights to access the information collected about me, except in some circumstances where access may be legitimately withheld. I will be given an explanation in these circumstances.)	
我明白，如果我的信息被用于以上所列的目的之外，需要先得到我进一步的同意。 (I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.)	
我同意我的个人信息被用于以上所列出的目的，但我已申明的关于使用和泄露的限制的情况除外。 **(I consent to the handling of my information by the practice for the purpose set out above, subject to any limitations on access or disclosure of which I notify this practice.)**	
或(OR)	
我因不确定，希望在签署此同意书之前与医疗保健的相关人员进一步讨论。 (I am unsure and would like to discuss this further with someone from the medical practice before I sign.)	

患者姓名 (Name)_____ 日期 (Date)_____ / _____ / _____

患者签名 (Signature)_____

儿童监护人签名 (Child)_____

儿童监护人姓名（正楷）(Name Printed)_____