New Patient Information Form

We are committed to providing our patients with the best care. To do this, it is essential that your health record contains complete and accurate information. Please assist us by completing your new patient record form:

Contact Information

Gender:	☐ Male ☐ Female ☐ Other
Title:	_____
Surname:	_____
First Names:	_____
Date of Birth:	_____
Street Address:	_____
Postal Address: *(if different to above)*	_____
Home Phone:	_____
Work Phone:	_____
Mobile Phone:	_____
Email:	_____

For medicare claiming purposes, if patient is under the age of 18years, a person over the age of 18 years must be nominated (e.g. parent, guardian, etc) Name: _____

DOB: _____ (Parent/ Guardian/ other (please specify): _____

Next of Kin

Name: _____ Relationship to you: _____

Home Phone: _____ Mobile Phone: _____

Address: _____

Emergency Contact Details

Name: _____ Relationship to you: _____

Home Phone: _____ Mobile Phone: _____

Healthcare Identifiers

Medicare Number: ☐☐☐☐☐☐☐☐☐☐ Ref: ☐☐ Expiry ☐☐/☐☐

Dept. of Veterans' Affairs File Number: _____ ☐ Gold ☐ White

Department of Human Services Card Number: _____ Expiry: ___/_____/_____

☐ Pension Concession ☐ Health Care Card ☐ Commonwealth Seniors Health Card

Cultural Identity

To assist with health initiatives – Do you identify as Aboriginal and/or Torres Strait Islander?

☐ No ☐ Yes – Aboriginal ☐ Yes - Torres Strait Islander ☐ Yes - Aboriginal and Torres Strait Islander

As Australia is a genuinely multicultural society, and to tailor appropriate care, encourage understanding and appreciation between people from different nationalities and cultures - do you identify as someone from a culturally and/or linguistic diverse background?

☐ No

☐ Yes - Please elaborate _____

If yes, do you require an interpreter service? ☐ No ☐ Yes

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Your Health Information

ALLERGY INFORMATION - Do you have any allergies or are you sensitive to drugs or dressings?

☐ No

☐ Yes – provide details: _____

CURRENT MEDICATIONS – Please list all your current medications, including complementary and over-the-counter medicines (e.g. homeopathic medicines such as vitamins and minerals etc.)

1. _____ 4. _____
2. _____ 5._____
3. _____ 6._____

MEDICAL HISTORY - Do you have or have you had a history of the following?

☐ Chronic Illness

☐ Asthma

☐ Diabetes

☐ Hypertension

☐ Medical History Details: _____

☐ Surgical History Details: _____

LIFESTYLE RISK FACTOR INFORMATION

Smoking

☐ No

☐ Ceased - date_____

☐ Yes - how many ___ day / week

Alcohol

☐ No

☐ Yes - how many ___ day /week /month

Recreational Drug Use

☐ No

☐ Yes - type_____ frequency _____

Family Health History Information

Have any members of your family have:

☐ Heart Disease

☐ Asthma

☐ Diabetes

☐ Hypertension (high blood pressure)

☐ Mental Illness

☐ Cancer – type:

☐ Other significant - provide details:

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Patient Consent

Please read this consent form carefully prior to signing.

This general practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose and treat illnesses and medical conditions, ensuring we are proactive in your health care. To enable ongoing care, and in keeping with the *Privacy Act 1988* and *Australian Privacy Principles*, we wish to provide you with sufficient information on how your personal information may be used or disclosed and record your consent or restrictions to this consent.

Your personal information will only be used for the purposes for which it was collected or as otherwise permitted by law, and we respect your right to determine how your information is used or disclosed.

The information we collect may be collected by a number of different methods and examples may include: medical test results, notes from consultations, Medicare details, data collected from observations and conversations with you, and details obtained from other health care providers (e.g. specialist correspondence).

By signing below, you (as a patient/parent/guardian) are consenting to the collection of your personal information, and that it may be used or disclosed by the practice for the following purposes:

- Administrative purposes in the operation of our general practice.
- Billing purposes, including compliance with Medicare requirements.
- Disclosure to others involved in your health care, 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 the referrals.
- Accreditation and quality assurance activities to improve individual and community health care and practice management.
- For legal related disclosure as required by a court of law.
- For the purposes of research only where de-identified information is used.
- To allow medical students and staff to participate in medical training/teaching using only de-identified information.
- To comply with any legislative or regulatory requirements, e.g. notifiable diseases.
- For use when seeking treatment by other doctors in this practice.

At all times we are required to ensure your details are treated with the utmost confidentiality. Your records are very important and we will take all steps necessary to ensure they remain confidential.
Please complete the form below if you understand and agree to the following statements in relation to our use, collection, privacy and disclosure of your patient information.

New Patient Information Form

I, the undersigned, have read the information above and understand the reasons why this information must be collected, and the purposes for which this information may be used or disclosed. I understand that if this information is to be used for any purpose other than that set out above, my further consent will be obtained.

I, the undersigned, give permission for my/ the patients' personal information to be collected, used and disclosed as described above. I understand that only relevant personal information will be provided to allow the above actions to be undertaken and I am free to withdraw, alter or restrict my consent at any time by notifying this practice in writing.

Patient name: (please print) _____

Signature: _____ Date: _____

If not patient signing - your name (please print)_____

Your relationship to patient (e.g. Mother, Father, guardian) _____

PRACTICE USE ONLY:

Witnessed by: (staff signature) _____

Consent to Contact:

Our practice provides our patients with preventive care and early case detection reminders issued by either SMS or Letter eg. Pap smears, annual health checks etc.

Our practice has a recall system in place whereby, if results need to be followed up with an appointment, an SMS, telephone call or recall letter is organised.

Even when you agree to be included in the Recall and Reminder system, you should remember when you should be tested for certain conditions and should always contact your doctor to get the results of a test that has been performed. We may not always be able to reach you, especially if you have moved and the contact information on your records has not been updated.

Please sign to give your consent for us to contact you and/or your family members:

Signature: _____ **Print Name:** _____