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:	
Title:	
Surname:	
First Name:	
Date of Birth:	
Street Address:	
Postal Address: *(if different to above)*	
Home Phone:	
Work Phone:	
Mobile Phone:	
Email:	

Emergency Contact Details	
Name:	Relationship to you:
Home Phone:	
Mobile Phone:	

Next of Kin	
Name:	Relationship to you:
Home Phone:	
Mobile Phone:	

Healthcare Identifiers

Medicare Number: _____ Ref: _____ Expiry: ___/_____

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

Concession (Pension/Health Care) Card Number: _____ Expiry: ___/_____

Cultural Identity

To assist with health initiatives - are you 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.)

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

☐ Surgery – provide details:

☐ Asthma

☐ Diabetes

☐ Hypertension

☐ Chronic Illness

☐ Other – provide 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 _____

Measurements

Height _____cm

Weight _____kgs

Occupation: _____

Family Health History Information

Do any members of your family have: (provide details & family members)

☐ Heart Disease

☐ Asthma

☐ Diabetes

☐ Hypertension (high blood pressure)

☐ Mental Illness

☐ Cancer – type:

☐ Other significant - provide details:

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.
- Follow-up reminder/recall notices for treatment and preventative healthcare, frequently issued by SMS.
- Disclosure to others involved in your health care, including treating doctors, specialists and Insurance agencies involved in funding and facilitating your healthcare, outside of this medical practice. This may occur through referral to other doctors or allied health professionals, 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.

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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.

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

I, _____ give permission for my personal information to be collected, used and disclosed as described above, including contact via SMS to my mobile phone number and emailed by my provided email address. I understand only my 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.

I, _____ give permission for my personal information to be collected, used and uploaded into My Health Record.

I, _____ understand that I have the right to revoke my consent to share my medical information, and any exclusions to my consent must be done so in writing or explicitly stated below.

_____

Patient name: (please print) _____

Signature: _____ Date:_____

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

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