New Patient Information Form

MAIDEN GULLY MEDICAL PRACTICE

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

Please Circle – Mr Mrs. Ms. Master Miss Date of Birth _____/_____/_____

Given Name(s) _____ Family Name(s) _____

Gender _____ Mobile _____Work Phone _____

Home Phone _____ Email _____

Street Address _____Suburb _____

Postcode _____ Postal Address _____

(If different from above)

Healthcare Identifiers

Medicare Number _____ Ref _____ Expiry _____/_____

DVA File Number _____ ☐ Gold ☐ White

Pension/HHC Number _____ Expiry _____/_____/_____

Emergency Contact/Next of Kin Details

Next of Kin

Name _____ Relationship _____

Contact Number _____

Emergency Contact

Name _____ Relationship _____

Contact Number _____

Cultural Identity

To assist with health initiatives – are you Aboriginal and/or Torres Strait Islander?

☐ No ☐ Yes – Aboriginal ☐ Yes – Torres Strait Islander ☐ Yes – Both of the above

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 culturally and/or linguistic diverse background?

☐ No

☐ Yes – Please elaborate _____ *If yes, do you require an interpreter service?* ***Yes / No***

Religion _____ Occupation _____

Your Health Information

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

☐ No

☐ Yes – Provide details _____

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

_____

MEDICAL HISTORY – Do you have/have you had a history of the following?

☐ Surgery – Provide Details _____

☐ Asthma ☐ Chronic Illness ☐ Hypertension

☐ Diabetes ☐ Other _____

LIFESTYLE INFORMATION *(Please Circle)*

Smoking – Yes / No If No – Ceased Date _____/_____/_____ If Yes – How many/Day? _____

Alcohol – Yes / No If Yes – How many/Day? ____

Recreational Drug Use – Yes / No If Yes – Type _____ Frequency _____

Family Health History

Please mark if a family member has experienced any of the following:

Mother:

☐ Heart Disease ☐ Asthma ☐ Cancer

☐ Mental Illness ☐ Diabetes

☐ Hypertension ☐ Other _____

Father:

☐ Heart Disease ☐ Asthma ☐ Cancer

☐ Mental Illness ☐ Diabetes

☐ Hypertension ☐ Other _____

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 illness 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 several different methods. 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 notice for treatment and preventative healthcare, frequently issued by SMS.
- 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 the practice.

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Patient Consent

Please read this consent form carefully prior to signing)

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 the 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 number. 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.

Patient name *(please print)* _____

Signature _____ Date _____/_____/_____

If signing on behalf of a dependent – Your name *(please print)* _____

Your relationship to the patient (e.g., Mother, Father, Legal Guardian) _____

OFFICIAL (PRACITCE) USE ONLY:

Witnessed by *(staff signature)* _____ Date _____/_____/_____