New Patient Information Form

Contact Information	
Birth Sex:	Gender Identity:
Title:	
Surname:	
First Name:	Middle Name:
Date of Birth:	
Street Address:	
Postal Address: *(if different to above)*	
Home Phone:	
Work Phone:	
Mobile Phone:	
Email address: Occupation:	

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

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

Healthcare Identifiers

Medicare Card Number_____ Patient Reference____ Expiry____/_____

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

Pension Card Number: _____ Expiry: ___/____ OR

Healthcare Card Number:_____ Expiry:____/_____

Cultural Identity

To assist with health initiatives do you identify as -

☐ Australian ☐ Aboriginal ☐ Torres Strait Islander ☐ Both Aboriginal and Torres Strait Islander ☐ '9' Not Stated/inadequately described

Or Do you identify as someone from a culturally and/or linguistic diverse background?

☐ No ☐ Yes - Please State: _____ _____

As Australia is a genuinely multicultural society, and to tailor appropriate care, encourage understanding and appreciation between people from different nationalities and cultures -

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

☐ Ex Smoker Ceased - date_____

☐ Yes - how many ___ day / ___ week

Alcohol

☐ No

☐ Yes - how many days per week _____ Drinks per day ____

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. 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 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.

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. I understand only my relevant personal

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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) _____

If Patient is under the age of 17 Please give details of the paying Guardian for rebate purposes

Name: _____

D.O.B: _____

Address: _____

_____

Medicare Number: _____

Patient number on card: _____exp date: _____