New Patient Form

Title/Pronouns _____ First Name _____ Surname_____ DOB _____/_____/_____

(If Child - Parents Name _____) Gender (Birth):_____ Gender Identity:_____

Home Address: _____Suburb_____P/Code_____

PH: _____ Work _____ Mobile: _____

Medicare #_____/__ Exp Date_____ Veteran Affairs # _____ Gold/White

Email Address _____

Do you have a pension or health care card Yes No Number _____

Next of Kin/Emergency Contact

Next of Kin: Mr/Mrs/Miss Firstname _____Surname _____ Phone H_____M _____W_____
Emerg Contact *circle here if same as above* Yes/ No or complete below
Emerg Contact Mr/Mrs/Miss Firstname _____Surname _____ Phone H_____M _____W_____
Do you authorise us to contact or Discuss your medical conditions/health record info with your Next of Kin/Emerg YES/NO

Origin

Are you of Aboriginal or Torres Strait Islander origin Yes No
Please state your country of origin _____

Clinical History

Do you suffer from: Heart Disease Diabetes Asthma Hypertension Arthritis Other Chronic Illness _____

Allergies Yes No. If yes further information _____

Females Only Have you had a Pap Smear/Breast Check in the last 5 years **Yes** **No**, if so when _____

Social & Family History

Social History *Please tick/complete where applicable do you:* Live Alone Live # Parents Live with Partner/ & children Other _____
____ # of children in family. Marital status Married Defacto Single. Smoker **Yes** **No**
Hobbies/Sport _____ Other Info _____

Do any family members suffer from: Heart Disease Diabetes Asthma Hypertension Arthritis Other_____

Further Information

- SMS appointment reminders **Yes** **No**
- Our practice provides patients with preventative care and early case detection reminders, eg immunisations, pap smears etc, both internally and on a National recall system ie Pap Smear Reg. Do you wish to have reminders sent to you. **Yes** **No**
- I acknowledge that if my doctor recommends a test then it is my responsibility to have that test done, I understand it is also my responsibility to visit the doctor to review the results, I will not assume these results were normal should I not hear from my practice. **Yes** **No**

Privacy Information

To ensure the best quality of care for you, our practice is required to collect your personal and medical information. At times some of this information may need to be shared with other health professionals or we may be legally obligated to disclose this information . Our Practice also participates in quality improvement activities as directed by our National appraisal organisation for accreditation purposes, using de-identified patient data to ensure continuing quality improvement within our practice. All persons accessing your personal health information are bound by confidentiality. Our practice ensures your information security by following the 10 National Privacy Principles these are available for your viewing at www.privacy.gov.au. If you would like to discuss this further please ask your health care professional during your consultation.

Please read and tick if agreed below –

I have read the information above and I understand:

1. Why I must provide my personal information **Yes** **No**
2. I am aware of my rights to access my information (if not info is available at www.privacy.gov.au) **Yes** **No**
3. I consent to the handling of my information as outlined above **Yes** **No**
4. I consent to Doctors/Staff disclosing relevant information to Specialists or Hospitals for the sole purpose of the quality and continuity of my care. **Yes** **No**
5. I Consent to Doctors/staff contacting Medicare for the collection of information as may be required. **Yes** **No**

Signature of Patient/Guardian _____ Date _____

To ensure your confidentially we are required to view ID that includes your signature in an effort to ensure signature authenticity should any requests be made for your personal information at a future date.

_____ Reception to initial viewing of signature.