

NEW PATIENT INFORMATION FORM

Please help us to provide the best possible patient care by completing the following pages

** = This information is completely voluntary and may help individualise and enhance your care. Any information is strictly private and confidential*

TITLE	Mr Mrs Ms Miss Mst Other					
SURNAME				FIRST NAME		
DATE OF BIRTH	/ /		*GENDER	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Prefer not to say
ADDRESS						
					POSTCODE	
MAILING ADDRESS						
					POSTCODE	
PHONE NUMBERS	Mobile:		Home:		Work:	
MEDICARE CARE				REFERENCE No. (next to name)		EXP
DVA NUMBER				<input type="checkbox"/> GOLD	EXP	
				<input type="checkbox"/> WHITE		
PENSION or HEALTHCARE CARD			CRN:			EXP
PRIVATE HEALTH INSURANCE			Name of Company			
NEXT OF KIN	Name:.....		EMERGENCY CONTACT	Name:.....		
	Phone:.....			Phone:.....		
	Relationship to you:.....			Relationship to you:.....		
YOUR EMAIL						
*To tailor appropriate care, encourage understanding and appreciation between people and cultures – do you identify as someone from a culturally and/or linguistically diverse background?			<input type="checkbox"/> No <input type="checkbox"/> Yes, please elaborate _____			
			Do you require an interpreter service? <input type="checkbox"/> Yes <input type="checkbox"/> No			
			If yes, what language.....			
Are you (is the patient) of Aboriginal or Torres Strait Islander origin?			<input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Both <input type="checkbox"/> None			
SMOKING HISTORY	<input type="checkbox"/> Non-smoker					
	<input type="checkbox"/> Ex-smoker	Year stopped		<input type="checkbox"/> Light	<input type="checkbox"/> Moderate	<input type="checkbox"/> Heavy
	<input type="checkbox"/> Current smoker	Per day		Year started		
CURRENT ALCOHOL INTAKE	<input type="checkbox"/> Non-drinker					
	<input type="checkbox"/> Drinker	Days per week			Standard drinks per day	
ALLERGIES			<input type="checkbox"/> No <input type="checkbox"/> Yes, please list allergy and reaction			
*Are you sensitive to anything? Food, medications, dressings etc...						
ANY SIGNIFICANT PAST MEDICAL HISTORY?						
ANY SIGNIFICANT FAMILY HISTORY?						

***** PLEASE TURN OVER TO COMPLETE DECLARATION *****

Do you authorise the practice to send you SMS appointment confirmations? YES / NO

Our practice provides our patients with preventive care and early case detection reminders e.g. immunisations, annual health checks, skin checks and Pap smears

Do you wish to have any relevant reminders sent to you?

Yes – via mail **OR** Yes – SMS to this ph no: _____ No

Your Health Information

To enable ongoing care and total quality improvement within this practice and in keeping with the Privacy Act (1988) and the [Australian Privacy Principles](#), we wish to provide you with sufficient information on how your personal health information may be used or disclosed and record your consent or restrictions to this consent.

Your personal health 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 personal health information is used or disclosed.

The information we collected may be collected by a number of different methods and examples may include: medical test results, notes from consultations, Medicare and health insurance 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/guardian) are consenting, that on obtaining your personal health information it may be used or disclosed by the practice for the following purposes:

- follow up reminder/recall notices for treatment and preventive healthcare;
- for accounting procedures and the collection of professional fees;
- the diagnosis and treatment of any health condition, including the communication of relevant information only, to practice staff, specialists and other healthcare providers to ensure quality care is provided;
- Accreditation and Quality Assurance activities are conducted by professionally trained non-treating GPs and other professionally trained and qualified persons, e.g. General Practice Managers;
- For legal related disclosures as required by Court of Law;
- For the purposes of research where de-identified information is used;
- To allow medical students and staff to participate in medical training/teaching using only de-identified information;
- For disease notification as required by law;
- 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.

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

Patient (please print): _____

Signature: _____ Date: _____

If not the Patient signing – Your name (please print): _____