**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 is kept up to date and accurate.

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| --- | --- | --- |
| **Could you please assist us by completing the following:** | | |
| **Title :** 🞏 Dr 🞏 Mr 🞏 Mrs 🞏 Ms 🞏 Miss | **Date of Birth :** | |
| **Full Name :** | **Occupation:** | |
| **Full Address :** | **Home Phone :** | |
| **Mobile Phone :** | **Email :** | |
|  |  | |
| **Medicare Number & Ref** | #: | |
| 🞏 **DVA Gold** 🞏  **DVA White** (Please tick which) | #: | Expiry: |
| **Pension Number** | #: | Expiry: |
| **Health Care Card Number** | #: | Expiry: |
| **Private Health Cover** | Name: #: | Expiry: |
| **Next of Kin** (Name and Telephone number) |  | |
| **Emergency Contact** (Name and Telephone number of the person we can contact if needed) |  | |
| **How did You hear about the practice?** | | |
| 🞏Yellow pages 🞏Google 🞏 Other Internet search 🞏Business card  🞏Street Sign 🞏Word of Mouth 🞏Chemist  🞏Other, please specify: \_\_\_\_\_\_\_\_\_\_\_\_ | | |

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| **Reminder Systems** | |
| Our practice provides our patients with preventive care and early case detection reminders e.g. immunisations, annual health checks, skin checks and pap smears.  **If we need to contact you what is your preferred method of contact:**  🞏 Home Phone 🞏 Mobile 🞏 Mail |  |
|  | |
| **Patient Background** | |
| Australia is a genuinely multicultural society. To tailor appropriate care, encourage understanding and appreciation between people from different nationalities and backgrounds.  **Do you identify as someone from a culturally and/or linguistic diverse background?**  🞏 No 🞏 Yes. Please elaborate:  Country of birth: Spoken Languages: | |
| **To assist with health initiatives – are you an Aboriginal or Torres Strait Islander?** | |
| 🞏 No 🞏 Yes – Aboriginal 🞏 Yes - Torres Strait Islander 🞏 Yes – Aboriginal & Torres Strait Islander | |

**Your Health History**

|  |
| --- |
| **Do you have or have you had a history of the following?** (please elaborate) |
| 🞏 Operations : |
| 🞏 Asthma 🞏 Diabetes 🞏 Hypertension |
| 🞏 Other medical conditions : |
| **Do you have any allergies or are you sensitive to drugs or dressings?** |
| 🞏 No 🞏 Yes. Please Advise each Drug and the reaction :   1. 2- 3-   4- 5- 6- |
| **Children’s Immunisations** |
| **If completing this form for a child are their immunisations up to date?** |
| 🞏 Yes 🞏 No |
| **Current Medications** |
| **Please list all current medications including over the counter medications, vitamins and minerals:** |
|  |

**Family History**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Have any members of your family had:** (please elaborate) | | | | |
| 🞏 Heart Disease 🞏Stroke 🞏 Asthma 🞏 Diabetes 🞏 Mental Illness 🞏 Cancer | | | | |
|  | | | | |
| **Do you use any of the following:** (list amount where appropriate) | | | | |
| Tobacco | 🞏 No.  🞏 Yes. Number \_\_\_\_ day / \_\_\_\_ week **or** 🞏 Ceased smoking | | | |
| Alcohol | 🞏 No.  🞏 Yes. Number \_\_\_\_ day / \_\_\_\_ week / \_\_\_\_ month | | | |
| Drug Use | 🞏 No.  🞏 Yes. Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ / Frequency \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **Females** | | | | |
| **When did you last have?** | | | | |
| Pap Smear | | Date: | 🞏 Not sure | 🞏 Never |
| Breast Check | | Date: | 🞏 Not sure | 🞏 Never |

Health Information Collection and Use   
Consent Form *St George Medical Group*

As a patient of our medical practice we require you to provide us with your personal details and a full medical history, so that we may properly assess, diagnose, treat and be proactive in your health care needs.

We aim to protect the privacy and secure storage of your health information. You can request a copy of our privacy policy, which includes information about the collection, use and disclosure of your health information.

We require your consent to collect personal information about you and to use the information you provide in the following ways. Please read this consent form carefully, and sign where indicated below.

* Administrative purposes in running our medical practice.
* Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
* Disclosure to others involved in your healthcare including treating doctors and specialists outside this medical practice. This may occur though referral to other doctors, or for medical tests and in the reports or results returned to us following referrals.
* Disclosure to other doctors in the practice, locums etc. attached to the practice for the purpose of patient care and teaching.
* For research and quality assurance activities to improve individual and community health care and practice management. Usually information that does not identify you is used but should information that will identify you be required you will be informed and given the opportunity to “opt out” of any involvement.
* To comply with any legislative or regulatory requirements e.g. notifiable diseases.
* For reminder letters which may be sent to you regarding your health care and management.

You can decline to have your health information used in all or some of the ways outlined above but it may influence our ability to manage your health care to provide the best outcome for you.

|  |  |
| --- | --- |
| I have read the information above and understand the reasons why my information must be collected. |  |
| I understand that I am not obliged to provide any information requested of me, but failure to do so may compromise the quality of health care and treatment given to me. |  |
| I am aware of my rights to access the information collected about me, except in some circumstances where access may be legitimately withheld. I will be given an explanation in these circumstances. |  |
| I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained. |  |
| I consent to the handling of my information by the practice for the purpose set out above, subject to any limitations on access or disclosure of which I notify this practice. |  |
| **OR** | |
| I am unsure and would like to discuss this further with someone from the medical practice before I sign. |  |

As a private billing medical clinic, Fees will be charged & expected to be paid on the day of

appointment. All payments must be done in person or over the phone so we can process the Medicare

rebate (if applicable) back to the patient. EFT payment is not available for patients. If you receive an

invoice, please contact the clinic to pay as advised above.

I acknowledge that I am aware of the billing policy above which is listed on our websites and info sheet.

Patient’s name: **………………………………………**  Date: **………………**

Patient’s signature: **………………………………**

**Signed as Guardian for child:** ………………………………   
**Name:** (printed) ……………………………………