



## NEW PATIENT FORM

### Patient Details

Title: (please tick)			<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Mast <input type="checkbox"/> Miss		
Surname:		Given Name:			
Middle Name:		Preferred Name:			
Date of Birth:     /     /		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non- Gendered			
Country of Birth:		Occupation: <input type="checkbox"/> Retired (please tick)			
Do you identify as: (please tick) <input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Both <input type="checkbox"/> Neither					
Residential Address:		Suburb:		Postcode:	
Postal Address: <input type="checkbox"/> As above (please tick)		Suburb:		Postcode:	
Home:		Work:		Mobile:	
Do you consent for SMS reminders: <input type="checkbox"/> Yes <input type="checkbox"/> No					
Do you consent for electronic communication: <input type="checkbox"/> Yes <input type="checkbox"/> No					
How did you find out about us: <input type="checkbox"/> Facebook <input type="checkbox"/> Websearch <input type="checkbox"/> Billboard <input type="checkbox"/> Family/Friend <input type="checkbox"/> Doctor					
Email:					

### Medicare & Concession Card Information

Medicare Card No: \_\_\_\_\_ Ref No: \_\_\_\_ Expiry \_\_\_\_/\_\_\_\_/\_\_\_\_

Pension /  Health Care Card No: \_\_\_\_\_ Expiry \_\_\_\_/\_\_\_\_/\_\_\_\_  
(please tick)

DVA Card No: \_\_\_\_\_ DVA Condition:  Gold /  White (please tick)

## Next of Kin Details

Name:

Address:

Suburb:

Postcode:

Home:

Work:

Mobile:

Relationship to Patient:

## Emergency Contact Details

Name:

As above (please tick)

Address:

Suburb:

Postcode:

Home:

Work:

Mobile:

Relationship to Patient:

## Personal Medical Information

Allergies (if none, please write "nil known")

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Current Medication

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Significant Illnesses / Medical Problems (please include approximate year)

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Previous Operations (please include approximate year)

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Family History (please include all known significant problems / illnesses)

Father: \_\_\_\_\_

Mother: \_\_\_\_\_

Brothers & Sisters: \_\_\_\_\_

Grandparents: \_\_\_\_\_

Smoking History	Drinking History
Please Tick <input type="checkbox"/> Never smoked <input type="checkbox"/> Current smoker <input type="checkbox"/> Ex smoker  What year did you start? _____ What year did you Stopped? _____  How many cigarettes do you smoke per day? _____  Comments: _____	Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No  How many days per week? _____ Standard Drinks per day? _____  If you Don't drink Alcohol now, Did you in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No  Comments: _____

How did you find out about us?

Family/ Friend   
  Close to Home/ Work   
  Website   
  Online booking service   
  Other

Privacy Information

At this practice, we collect personal information from our patients for the primary purpose of providing quality health care services. 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.

To ensure the security of personal information held in this practice, all records are stored on computer, are password protected and are only accessible by authorised staff (all of whom have signed confidentiality agreements) within the practice. This practice will only use Medicare numbers collected from patients for the purpose of billing for medical services provided. The information you provide will only be for:-

- The primary purpose of providing quality health care services
- Administrative purposes for our medical practice
- Billing purposes, including compliance with Medical Australia requirements
- Disclosure to others involved in your health care, including treating doctors, specialists and medical technicians outside of this practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us
- Disclosure to other doctors within this practice, locum, for the purpose of patient care
- Disclosure for research and quality assurance activities (using only de-identified data) to improve individual and community health care and practice management.
- Disclosure to State and Commonwealth Reminder Systems Pap Smear Register, Immunisation Register for preventative health care

In other situations we would not disclose your personal information without obtaining your consent.

We will endeavour to ensure that all personal information collected is accurate, complete and correct.

Patients who wish to access their personal health information are welcome to discuss these matters with their treating doctors. Should access be denied, a reason for this denial will be provided to you. Should you require a copy of your personal information an administration fee may be incurred.

**I have read and understood** the information above and understand the reasons why my information must be collected.

I am also aware that this practice has a privacy policy on handling patient information.

I understand that if my information is to be used for any purpose other than set out above, my further consent will be obtained.

I therefore consent to the handling of my information by this practice for the purpose set out above, subject to any limitations on access or disclosure that I notify this practice of.

FEMALE PATIENTS

I agree to participate in State and Commonwealth Reminder Systems Pap Smear Register, Immunisation Register for preventative health care: Please tick:     I agree     I do not agree

Patient/Guardian Signature:

Date:    /    /