New Patient Information Form

COLLABORATIVE HEALTHCARE

We are committed to providing our patients with the best care. To do this, it is essential that your health record contains complete and accurate information. Please assist us by completing your new patient record form:

Contact Information			
Title:			
Surname:			
First Name:			
Date of Birth:	Gender	☐ Male	☐ Female
Street Address:			
Postal Address: (if different to above)			
Home Phone:	Mobile Phone:		
Email:			
Do you consent to receive appointment reminders via SMS?		☐ No	☐ Yes
If we need to contact you what is your preferred method of contact?		☐ Mobile ☐ Home	☐ Mail
Occupation:			

Healthcare Identifiers			
Medicare Number:	Ref:		Expiry: / /
Concession (Pension/Health Care) Card Number:			Expiry: / /
Dept. of Veterans' Affairs File Number:		☐ Gold	☐ White
Private Health: ☐ No ☐ Yes	Health Fund Name:	Membership No:	

Next of Kin			
Name:	Relationship to You:		
Home Phone:	Mobile Phone:		
If the patient is a child, is there currently any court orders in place relating to custody we should be aware of?		☐ No	☐ Yes

Emergency contact details	
Name:	Relationship to You:
Home Phone:	Mobile Phone:

Cultural identity			
To assist with health initiatives - are you Aboriginal and/or Torres Strait Islander?			
☐ No	☐ Yes – Aboriginal	☐ Yes – Torres Strait Islander	☐ Yes – both
To tailor appropriate care, encourage understanding and appreciation between people from different nationalities and cultures. Please identify your Country of origin.			
Do you require an interpreter service?	☐ No	☐ Yes	Please specify language:

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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?

☐ Asthma	☐ Hypertension	☐ Diabetes
☐ Chronic Illness	☐ Depression/Anxiety	

☐ Surgery – provide details:

☐ Other – provide details:

Your Health Information

LIFESTYLE RISK FACTOR INFORMATION

Smoking	☐ No	☐ Ceased – date: / /
	☐ Yes - how many: /day or /per week	
Alcohol	☐ No	
	☐ Yes, how often /day /week /month	
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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Privacy Statement and Consent

(Please read this consent form carefully prior to signing)

This general practice collects your information for the primary purpose of providing proactive health care and to enable us to properly assess, diagnose and treat illnesses and medical conditions. In keeping with the Privacy Act 1988 and Australian Privacy Principles, the following information is provided 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 to be used for the following purposes:

- Administrative and billing purposes in the operation of our general practice.
- Reminder/recall notices for treatment and preventative healthcare issued by telephone, SMS or mail.
- Disclosure to others involved in your health care (e.g. specialists, diagnostic testing) within and outside this medical practice.
- Accreditation and quality assurance and to comply with other legislative requirements.
- For legal related disclosure as required by a court of law.
- For the purposes of research and training only where de-identified information is used.

At all times we are required to take all steps necessary to ensure your information remains confidential. Please complete the details 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 other purpose other, my further consent will be obtained.

I give permission for my personal information to be collected, used and disclosed as described above. I understand only my relevant personal 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 (Patient/Parent/Guardian): _____ Date: / /

PRACTICE USE ONLY:

Witnessed by: (staff signature) _____