New Patient Form

Keeping you and your family in good health is our mission.
Please complete all the details in this form and return it to reception with your Medicare Card and Photo ID.

Title □ Mr □ Mrs □ Ms □ Miss □ Master □Doctor □Other ……

Surname …… **First Name** ……

Date of Birth ……/……/…… **Gender** □ Male □ Female □Other……

Address …… **Suburb** …… **Post Code** ……

Mobile Number …… **Other Phone Number** ……

Email Address ……

Next of Kin Name ……

Phone Number …… **Relationship to You** ……

Emergency Contact Person Name …… **or** □ **Same as NOK**

Phone Number …… **Relationship to You** ……

Ethnicity □ Aboriginal □ Torres Strait Islander □ Both □ Australian □ Other ……

Occupation …… □ Unemployed □ Student □ Retired

Medicare ….. ….. ….. ….. ….. ….. ….. ….. ….. ….. Expiry ……/…… Ref …… (In front of your name)

Centrelink Pension or Healthcare Card …… Expiry ……/……/……

Full Time Student ID Number …… Institution …… Expiry ……/……

DVA …… □ Gold □ White □ Orange

Do you have an electronic 'My Health Record'? □ Yes □ No □ Unsure

Do you consent to 'My Health Record' access and upload? □ Yes □ No

Do you consent to Appointment Reminder SMS? □ Yes □ No

Do you consent to Clinical Reminder SMS? □ Yes □ No

How did you hear about us?

□ Google Search □ Walking By □ Word of Mouth □ HealthEngine/Hotdoc □ Other

Book your next appointment online using Hotdoc. Download the app today.

HotDoc

Clinical Information Form

Allergies: Please list all allergies/sensitivities and reactions or □ None Known

Current Medications: Please list all medications/ supplements and dosage or □ None

Current Medical Conditions: Please list all known or □ None

Past Significant Medical Conditions: Please include hospitalisations or □ None

Lifestyle

Marital Status: □ Single □ De-Facto □ Married □ Divorced □ Widowed □ Other

Sexual Orientation: □ Heterosexual □ Homosexual □ Bisexual □ Prefer not to say □ Other

Accommodation: □ Own Home □ Shared Home □ Nursing Home □ Other

Live with: □ Alone □ Spouse □ Relative □ Friend □ Other

Are you a carer? □ Yes □ No Does someone care for you? □ Yes □ No

Do you smoke? □ Yes □ No If yes, how many / day ……

How much alcohol do you drink? Number of days/week …….. Number of drinks/ day……..

How much exercise do you do? Number of days/week …… Number of mins/ day ……

Women's Health

When was your last Cervical Screening? ……./……./……. Results were: □ Normal □ Abnormal

Men's Health

When was your last Prostate/PSA test? ……./……./…….. Results were: □ Normal □ Abnormal

Family History Please tick table if relevant

Are your parents alive? **Mother** □ Yes □ No **Father** □ Yes □ No

	Diabetes	High BP	Ischemic Heart Disease	Stroke	Depression	Asthma	Cancer (specify type)	Other
Mother								
Father								
Brother								
Sister								

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Patient Consent

Patients of our Medical Centre are required to provide us with your personal contact details and medical history so we may properly assess, treat and be proactive in the management of your health and wellbeing.

We provide our services within the Privacy Act 1988. Our complete Privacy Policy is available at reception or on our website. Your health information will be used only for the purposes it is collected or permitted by law.

By signing this form, you consent to your information being used for:

- Administrative purposes in running of the medical centre
- Accounting procedures and collection of professional fees
- Disclosure of medical records and health information to other doctors within our practice and affiliated practices of the group
- Communication to specialists, hospital staff, pathology labs and pharmacies involved in your medical care
- Accreditation and Quality Improvement activities with de-identified information
- Compliance with any legislative or regulatory requirements
- For clinical follow up communications by SMS, email and letters

Please read this consent form carefully, tick the relevant boxes and sign where indicated.

I have read the information above and understand why my details are collected	□
I understand I am not obliged to provide information requested by failure to do may compromise my quality of healthcare and treatment received.	□
I am aware of my rights to access information collected about me and the circumstances where it can be withheld.	□
I understand that if my information is to be used for any other purposes, my consent will be obtained	□
I consent to my information being handled by the medical centre as described above	□
I agree that if I fail to attend or give 1 hours' notice for a GP appointment, I will be required to pay a $20 Non Attendance Fee	□

Patient's Name .....

Patient/Guardian's Signature .....

Date ...... / ...... / .....