New Patient Form

Title: ______________________________

Surname: ___________________________

Name: ______________________________

Date of Birth: _______________________

Gender: ☐ Male ☐ Female

Marital Status:

☐ Single ☐ Married
☐ De facto ☐ Separated
☐ Divorced ☐ Widowed

Address:______________________________

____

Suburb: _____________Postcode: __________

Phone (home): ______________________

Phone (work): _______________________

Mobile: ______________________________

Your occupation: ____________________

Medicare No: ________________________________

Line No: ___________ Expiry: ___________

Pension/HCC/Vet Affairs: ______________________

Expiry: _______________________________________

Next of Kin:
Name: _______________________________________

Relationship to you: ___________________________

Phone (home): ________________________________

Phone (work): _________________________________

Mobile: _______________________________________

Emergency Contact
Name: _______________________________________

Relationship to you: ___________________________

Phone (home): ________________________________

Phone (work): _________________________________

Mobile: _______________________________________

Your Health History— do you have or have you had a history of?

☐ Operations: ____
☐ Asthma
☐ Diabetes
☐ Hypertension
☐ Chronic Illness
☐ Other: ____

Do you smoke? ☐ Yes ☐ No

Known Allergies: ____

Immunisations—have you had the following immunisations?

Tetanus Booster	Date: ______________	☐ Don't Know	☐ Haven't had one
Hepatitis B	Date: ______________	☐ Don't Know	☐ Haven't had one
Hepatitis A	Date: ______________	☐ Don't Know	☐ Haven't had one
Influenza	Date: ______________	☐ Don't Know	☐ Haven't had one
Pneumococca	Date: ______________	☐ Don't Know	☐ Haven't had one
Polio	Date: ______________	☐ Don't Know	☐ Haven't had one

Children's immunisations—if completing this form for a child, are his/her immunisations up to date?

☐ Yes ☐ No

To assist with Health Initiatives: Are you of Aboriginal or Torres Strait Islander origin?

☐ No ☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal & Torres Strait Islander

Describe cultural background: ____

How did you hear about Medical on Church?

☐ Word of mouth ☐ Internet ☐ Letterbox leaflet ☐ White Pages
☐ Passing by ☐ Previous Patient ☐ Yellow Pages ☐ Other _________________

Please turn over to complete consent

Medical on Church
DCGPA 2012

Health Information Collection and Use Consent Form

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 eg 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. Please place your initial next to each of the statements below to denote your agreement.

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.

Patient’s Name: ____________________________ Patient’s Signature: ________________________

Signed as Guardian for the child: _________________________ Name: ______________________

Date: _________/___________/____________