New Patient Information Form

We are committed to providing our patients with the best care.
To do this it is essential that your medical records are up to date and accurate.

Could you please assist us by completing the following information!

Title Miss Mrs Ms Mr Dr Master Miss Other ***(please circle)***

Family Name: ……..

Given Name: …….

Middle Name: ……..

Preferred Name: ……

DOB: …….. Sex: Male Female ***(please circle)***

Ethnicity: ***(please circle)*** Aboriginal Torres Strait Islander/ Aboriginal/ Non Aboriginal /Torres Strait Islander/Australian/ Other……..

Address: ……

City/Suburb: ……..……Postcode……..…..

Postal Address (if different): ……..

Home Phone: …….

Work Phone: ……..

Mobile Phone: ……Email: ……

Preferred contact: Home Phone Work Phone Mobile Phone *(please circle)*

Do you consent to SMS reminder messages Yes/No (please circle)

Medicare no: ……..Ref#.....Expiry#.....

Pension/ Health Care Card # ……..... Expiry#.....

Pension card type: Pension concession/ Health care/ commonwealth seniors ***(please circle)***

DVA no: ……DVA type: Gold/ White/ Lilac / Orange ***(please circle)***

Religion: …….....

Head of Family: …….

Next of Kin: ……..….Relationship: …….Phone: ……

Emergency contact: ……....Relationship: …….Phone: ……...

Your Occupation: ……..……

This question must be answered:

Do you have any allergies or are you sensitive to drugs or dressings:

……..……

How did you learn about FMP? ***(Please tick)***
Face Book ☐ Newspaper ☐ Radio ☐ Letterbox flyer ☐ Word of mouth ☐Shopping centre ☐ Chemist ☐ Family Attends ☐ TV AD ☐ White Pages ☐ Yellow Pages / Online/ ☐ Directory Assist Other ☐ ……

Please turn over to complete…….

Our practice provides our patients with preventive care and early case detection reminders, e.g. immunisations, annual health checks, skin checks and pap smears.

Do you wish to have any relevant health reminders sent to you?

❑ Yes ❑ No

Do you have any health concerns you would like to receive more information about?

_____

_____

Your health History- Do you have or have you had a history of?

☐ Operations

☐ Asthma

☐ Diabetes

☐ Hypertension

☐ Chronic Illness

☐ Other

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

Pneumococcal Date: _____ ☐ Don't know ☐ Haven't had one

Polio: _____ ☐ Don't know ☐ Haven't had one

Children's immunisations- if completing this form for a child is their immunisations up to date?

☐ Yes ☐ No

Current Medication (including over the counter medications, vitamins and minerals)

_____

_____

Family History- Has any members of your family had?

☐ Diabetes Which family member_____

☐ Asthma Which family member_____

☐ Heart Disease Which family member _____

☐ Mental illness Which family member _____

☐ Cancer Which family member _____

Social history

☐ Tobacco: _____ day / week or ceased smoking date_____

☐ Alcohol: _____ day / week/ month (circle the one applicable)

Drug use: _____ (type and frequency)

Height: _____ cms **Weight**: _____ kgs

Blood pressure: *When was the last time your blood pressure was taken?* _____

Please turn over to complete…….

Sun Protection: *How often do you use the following to protect yourself from the sun when outdoors?*

	Always	Often	Sometimes	Rarely	Never
Protective clothing	☐	☐	☐	☐	☐
Sunscreen	☐	☐	☐	☐	☐

For those 65 years and older: When was the last time you were immunized?

Influenza Date: _____ ☐ not sure ☐ never

Pneumoccoal pneumonia Date: _____ ☐ not sure ☐ never

Females: When did you last have?

Pap smear Date: _____ ☐ not sure ☐ never

Breast check Date: _____ ☐ not sure ☐ never

Males when did you last have?

An overall checkup Date: _____ ☐ not sure ☐ never

Patient Signature: _____ Date: _____

Thank you for completing this form which will form part of your confidential medical record.
Your doctor may request additional information during your consultation.

FMP Patient Consent Form – Health information collection, use and disclosure.

This general practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose and treat illnesses and medical conditions, ensuring we are proactive in your health care. To enable ongoing care, and in keeping with the *Privacy Act 1988* and *Australian Privacy Principles*, we wish to provide you with sufficient information on how your personal information may be used or disclosed; we will 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.

The information we collect may be collected by a number of different methods, and may include, but not limited to: medical test results, notes from consultations, Medicare details, data collected from observations and conversations with you, and details obtained from other health care providers (e.g. specialist correspondence).

By signing below, you (as a patient/parent/guardian) are consenting to the collection of your personal information, and that it may be used or disclosed by the practice for the following purposes:

- Administrative purposes in the operation of our general practice.
- Billing purposes, including compliance with Medicare requirements.
- Follow-up reminder/recall notices for treatment and preventative healthcare, frequently issued by SMS.
- Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals.
- Accreditation and quality assurance activities to improve individual and community health care and practice management.
- For legal related disclosure as required by a court of law.
- For the purposes of research only where de-identified information is used.
- To allow medical students and staff to participate in medical training/teaching using only de-identified information.
- To comply with any legislative or regulatory requirements, e.g. notifiable diseases.
- For use when seeking treatment by other doctors in this practice.

At all times we are required to ensure your details are treated with the utmost confidentiality. Your records are very important and we will take all steps necessary to ensure they remain confidential.

Please complete the form below if you understand and agree to the following statements in relation to our use, collection, privacy and disclosure of your patient information.

Consent

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 purpose other than that set out above, my further consent will be obtained.

I, _____ give permission for my personal information to be collected, used and disclosed as described above, including contact via SMS to my mobile phone number. I understand that 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: _____ Date:_____

If not patient signing - your name (please print)_____

Your relationship to patient (e.g. Mother, Father, guardian)_____

PRACTICE USE ONLY:

Witnessed by: (staff signature) _____