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 select)***

Family Name: ……..

Given Name: …….

Middle Name: ……..

Preferred Name: …….

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

Gender: Female /Male /Non-Binary /Transgender /Gender Diverse/ Different Identity ***(please circle)***

Pronouns: she/her/hers he/him/his they/them/theirs ***(please circle)***

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

Country of Birth: …… Preferred Language: …….

Address: ……

City/Suburb: ……..

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#.....

Pensioner Card/ Health Care Card/ Seniors Card *(please circle)*

……..... Expiry number .....

Pension card type: Pension concession/ Health care/ Commonwealth Seniors ***(please circle)***

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

Religion: …….....

Head of Family: …….

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

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

Your Occupation: ……

Please turn over to complete…….

This question must be answered:

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

……

Reminder Systems:

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

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…….

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 any 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. We respect your right to determine how your information is used or disclosed.

The information we collect may be obtained through a variety of methods and may include, but is not limited to: medical test results, notes from consultations, Medicare details, data collected from observations and conversations with you, and information received 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 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.
• To support clinical and administrative functions through the use of artificial intelligence (AI) tools, where such tools are used to assist practitioners in delivering more accurate and efficient care(note taking). Any AI tools used will only process your data in accordance with applicable privacy and security standards, and identifiable information will not be shared externally without your consent.

At all times, we are required to ensure your personal information is treated with the utmost confidentiality. Your records are very important, and we will take all necessary steps to ensure they remain private and secure.

Please complete the form below if you understand and agree to the above statements in relation to the collection, use, privacy, and disclosure of your personal 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) _____

Please give this form back to reception. Thank you.