

# New Patient Information Form

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   |  |
|---|--|
| Gender:   |  |
| Title:  |  |
| Surname:  |  |
| First Name:   |  |
| Date of Birth:  |  |
| Street Address:   |  |
| Postal Address:<br><i>(if different to above)</i>   |  |
| Home Phone:   |  |
| Work Phone:   |  |
| Mobile Phone:   |  |
| Email:  |  |
| Emergency Contact Details   |  |
| Name:   | Relationship to you:   |
| Home Phone:   |  |
| Mobile Phone:   |  |
| Next of Kin   |  |
| Name:   | Relationship to you:   |
| Home Phone:   |  |
| Mobile Phone:   |  |
| Healthcare Identifiers  |  |
| Medicare Number: _____  | Ref: _____ Expiry: __/__/____                                |
| Dept. of Veterans' Affairs File Number: _____   | <input type="checkbox"/> Gold <input type="checkbox"/> White |
| Concession (Pension/Health Care) Card Number: _____   | Expiry: __/__/____   |
| Cultural Identity   |  |
| To assist with health initiatives - are you Aboriginal and/or Torres Strait Islander?   |  |
| <input type="checkbox"/> No <input type="checkbox"/> Yes – Aboriginal <input type="checkbox"/> Yes - Torres Strait Islander <input type="checkbox"/> Yes - Aboriginal and Torres Strait Islander  |  |
| As Australia is a genuinely multicultural society, and to tailor appropriate care, encourage understanding and appreciation between people from different nationalities and cultures - do you identify as someone from a culturally and/or linguistic diverse background? |  |
| <input type="checkbox"/> No<br><input type="checkbox"/> Yes - Please elaborate _____  |  |
| <i>If yes, do you require an interpreter service?</i> <input type="checkbox"/> No <input type="checkbox"/> Yes  |  |

# New Patient Information Form

## 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?

- Surgery – provide details:
- Asthma
- Diabetes
- Hypertension
- Chronic Illness
- Other – provide details:

## LIFESTYLE RISK FACTOR INFORMATION

### Smoking

- No
- Ceased - date \_\_\_\_\_
- Yes - how many \_\_\_ day / \_\_\_ week

### Alcohol

- No
- Yes - how many \_\_\_ 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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## Patient Consent

**Please read this consent form carefully prior to signing.**

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 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.

The information we collect may be collected by a number of different methods and examples may include: 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.

## New Patient Information Form

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.

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.

Would you like to be contacted via SMS (mobile text message) for: appointment reminders, recalls, & other text reminders or medical services we offer. **YES/NO**

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: \_\_\_\_\_ 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) \_\_\_\_\_

# New Patient Information Form

KING STREET MEDICAL CENTRE  
AND  
CABARITA BEACH MEDICAL CENTRE

1<sup>st</sup> April 2018

## RE: APPOINTMENT NON-ATTENDANCE POLICY

King street & Cabarita Beach Medical Centres have a continuing problem with non-attendance at booked appointments.

This is disadvantaging other unwell patients who could use this appointments time.

As a result, we have been forced to introduce a **“NON-ATTENDANCE FEE”**.

As of April 1<sup>st</sup>, 2018, if you are unable to attend a booked appointment, please notify us with at least 2 hours notice so that we can offer the appointment to another patient. If you do not attend an appointment, or notify us less than 2 hours prior, there will be a **\$15.00 fee**.

After 2 missed appointments all outstanding non-attendance fees must be paid before another appointment will be given.

If you are a new patient and have not attended your initial appointment you will be unable to be give another appointment until your non-attendance fee has been paid.

Yours sincerely,  
Management of King Street and Cabarita Beach Medical Centres

Patient Name :

Signature:

Date: