New Patient Information Form

ERIC STREET MEDICAL

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: ☐ Male ☐ Female Other..... Title: Mr/Mrs/Ms/Miss Other.....

Surname:.....First Name:.....Date of Birth:.....

Mobile P:.....Home Ph:.....Work Ph:.....

Email:.....

Street Address:.....Suburb:.....Postcode:.....

Postal Address *(If different to above)*.....Suburb:.....Postcode:.....

Next of Kin

Name:..... Relationship to you:.....

Home Ph:..... Mobile:.....

Emergency Contact Details

Name:..... Relationship to you:.....

Home Ph:..... Mobile:.....

Healthcare Identifiers

Medicare Number:.....Ref:..... Exp:...../.....

Dept of Veteran's Affairs File Number:..... ☐Gold ☐White Condition:.....

Concession (Pension/Health Care) Card Number:.....Exp:...../.....

Cultural Identity

To assist with health initiatives – are you Aboriginal and / or Torres Strait Islander?

☐ No ☐ Yes – Aboriginal ☐Yes – Torres Strait Islander ☐ Yes – Aboriginal and Torres Strait Islander

Do you identify as someone from a culturally and/or linguistically diverse background?

☐ No ☐ Yes – Please elaborate.....

If yes, do you require an interpreter service? ☐ No ☐ Yes

What is your country of Birth?

☐ Australia ☐ Other.....

Your Health Information

ALLERGY INFORMATION – Do you have any allergies or are you sensitive to drugs or dressings? ☐ No ☐ Yes

If yes please 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,)

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MEDICAL HISTORY – Do you have or have you had a history of the following?

☐ Surgery – Please provide details.....

☐ Asthma ☐ Diabetes ☐ Hypertension ☐ Chronic Illness.....

☐ Other – Please provide details .....

LIFESTYLE RISK FACTOR INFORMATION – *Alcohol:* ☐ No ☐ Yes – How many .....day / .....week / .....month

Smoking: ☐ No ☐ Ceased – date..... ☐ Yes – How many .....day / .....week

Recreational Drug Use: ☐ No ☐ Yes – type..... frequency.....

FAMILY HEALTH HISTORY INFORMATION – Do any members of your family have:

☐Heart Disease ☐ Asthma ☐ Diabetes ☐ Hypertension (High Blood Pressure) ☐ Mental Illness

☐ Cancer – Type:..... ☐ Other Significant – provide details:.....

Please turn over

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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 (via email, fax or post) 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 completed 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 purpose 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 email and SMS to my mobile phone number. 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)……Signiature:……Date……

If not patient signing – your name ……Relationship to patient……