NEW PATIENT APPLICATION FORM

Title: _____ Name: _____ Surname: _____ Preferred Name:_____

Date of Birth: _____ Gender at birth: ☐ Male ☐ Female Gender Identity: _____

Do you identify as any of the following:

Please Tick: ☐ Heterosexual ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Transgender ☐ Intersex Other:_____

(Only complete this question if you are aged 15 and over)

Phone: Mobile: _____ Phone: Work: _____

Knowing your cultural background can help us provide health care that meets your individual needs

Do you identify as any of the following:

Please tick: ☐ Aboriginal ☐ Torress Strait Islander ☐ Aboriginal and Torress Strait Islander ☐ Neither

If yes, have you previously registered for closing the gap? ☐ Yes ☐ No

Medicare Number: _____ Ref No: _____ Expiry Date: _____

Please tick: ☐ Pension Card ☐ Veterans Affair Card ☐ Health Care Card ☐ Commonwealth Seniors Card

Private Health: ☐ Yes ☐ No If Yes: ☐ Basic ☐ Intermediate ☐ Top

Concession Card Number: _____ Expiry Date: _____

Type of Veterans Affair Card: _____

MyMedicare Registered: ☐ Yes ☐ No Regular Practitioner: _____

Residential Address: _____ Postcode: _____

Postal/P. O (if not same as above) _____ Postcode: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Defacto ☐ Separated

Occupation: _____ Email: _____

Consent to receive communication via email-text: ☐ Email ☐ Text

Country of birth: _____ Ethnicity: _____

Do you need an interpreter: ☐ No ☐ Yes If yes, please specify language: _____

Next of Kin: _____ Relationship to patient: _____ Phone number: _____

Emergency contact: As above/Other: Name: _____ Phone Number: _____

Relationship to patient:_____

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Allergies: ☐ No ☐ Yes: Item, Nature of reaction, Severity:_____

Do you have or ever had:

Condition	Yes	Date of diagnosis	Condition	Yes	Date of diagnosis
Arthritis			Heart attack		
Asthma			High blood pressure		
COPD/Emphysema			High cholesterol		
Bowel condition			Kidney, bladder or urinary problems		
Epilepsy			Hearing		
Diabetes			Vision		
Cancer-please specify			Any other long-term condition please specify		

Please list any surgical operations and the date if known.

_____

_____

_____

_____

Please list any medications you are currently taking and their dose, include any alternative medicine or over the counter e.g. Mylanta, vitamin's.

_____

_____

_____

_____

How often do you have a drink containing alcohol.

☐ Never ☐ Monthly or Less ☐ 2-4 times a month ☐ 2-3 times a week ☐ 4or more times a week

How many standard drinks containing alcohol do you have on a typical day.

☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 to 9 ☐ 10 or more

How often do you have 6 or more drinks on one occasion.

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

Smoking: ☐ Non-smoker ☐ Ex smoker (Quit date): _____ ☐ Smoker: Number per day: _____

Year Commenced: _____

Weight: _____ Height: _____

Have any of your mother, father, siblings or grandparents ever suffered from:

Heart disease		Diabetes	
Asthma		Prostate cancer	
Bowel cancer		breast cancer	
Skin cancer/melanoma		Epilepsy	
Stroke		Depression and/or mental health illness	
Other please specify			

Have you ever served in the Australian defence force? If yes, please specify: _____

Please list any sports or hobbies you take part in: _____

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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 through referrals 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 e.g. 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.

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.

I understand that while efforts are made to maintain confidentiality, there are associated risks communicating via email

I understand that I may withdraw my consent to communicate via email at any time and will notify the practice of any changes to my details.

Patients Name: _____ Date: ____/____/____

Patients Signature: _____ Signed as Guardian for child: _____

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