NEW PATIENT APPLICATION FORM

Yeppoon Medical Care

Personal Details

Title _____ Name _____ Surname _____ Preferred Name _____

Date of Birth _____ Sex at Birth ◯ Male ◯ Female Gender Identity _____

Marital Status *(Please tick)* ◯ Single ◯ Married ◯ Defacto ◯ Separated ◯ Divorced ◯ Widowed

Occupation _____

Medicare Number _____ Ref No _____ Expiry Date _____

Knowing your cultural background and sexual orientations can help us provide health care that meets your individual needs. Do you identify as any of the following (please tick):
Cultural background:

◯ Aboriginal ◯ Torress Strait Islander ◯ Aboriginal and Torress Strait Islander ◯ None

Sexual Orientation *(Only complete this question if you are aged 15 and over)*:

◯ Heterosexual ◯ Gay ◯ Lesbian ◯ Bisexual ◯ Transgender ◯ Prefer not to answer ◯ Other: _____

Country of birth _____ **Ethnicity** _____

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

Contact Details

Residential Address _____ Postcode _____

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

Phone Mobile _____ Phone Work _____

Email _____

I consent to receive communication in relation to my health conditions (e.g. medical certificates, appointment reminders, recalls) via email and/or text message. This will not be used for marketing.

Email ◯ Yes ◯ No Text ◯ Yes ◯ No

Next of Kin

Name _____ Phone _____ Relationship to patient _____

Emergency Contact *(if not same as above)*

Name _____ Phone _____ Relationship to patient _____

Concession Cards

Have you ever served in the Australian Defence Forces? ◯ Yes ◯ No

DVA Card ◯ Gold ◯ White Card Number _____ Expiry Date _____

Health Care Card Number _____ Expiry Date _____

Pension Card Number _____ Expiry Date _____

Medical Details

Allergies ◯ None know

◯ Yes List item, nature of reaction: _____

_____

_____

Weight _____ kg Height _____ cm

Do you have ever had:

Condition	Yes	Year	Condition	Yes	Year
Arthritis	◯		Heart attack	◯	
Asthma	◯		Visually impaired	◯	
COPD/Emphysema	◯		Stroke	◯	
Cancer-please specify	◯		Mental Health condition (specify):	◯	
Severe hearing loss	◯		Bowel Condition	◯	
Epilepsy	◯		Diabetes	◯	
High blood pressure	◯		High cholesterol	◯	
Any other long-term condition (specify):	◯				

Please list any operations and the date/year if known:

Operation	Date/Year	Operation	Date/Year

Please list any medications you are currently taking:

Medication	Dose if known	Medication	Dose if known

Family History:
Please tick/list any family history that your parents, siblings or grandparents may have suffered from:

- ◯ Heart disease
- ◯ Asthma
- ◯ Breast Cancer
- ◯ Stroke
- ◯ Epilepsy
- ◯ Prostate Cancer
- ◯ Diabetes
- ◯ Bowel Cancer
- ◯ Depression/Mental Health Illness
- ◯ Other please specify _____

How often do you have a drink containing alcohol:

◯ Never ◯ Monthly or Less ◯ 2-4 times a month ◯ 2-3 times a week ◯ 4 or 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 History:

◯ Never smoked ◯ Ex smoker (Quit date): ◯ Smoker - Number per day: Year Commenced: _____

Please list any sports or hobbies you take part in:

HEALTH INFORMATION COLLECTION AND USE CONSENT FORM

Yeppoon Medical Care

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 can accurately assess, diagnose, treat and be proactive in your health care needs.
We aim to protect 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