



# New Patient Information Form

We need this information to provide the best quality care. This form complies with the Royal Australian College of GP's (RACGP) standards for general practice. This means your personal health information is kept private and secure, as required by federal and state privacy laws. If you have concerns, please leave blank and discuss with your GP.

► **Personal Details:**

Title: \_\_\_\_\_ Surname: \_\_\_\_\_ First Name(s): \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: Male  Female  Neutral  Other

Address: \_\_\_\_\_

Suburb: \_\_\_\_\_ Post Code: \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (Mobile) \_\_\_\_\_

**Consent to send SMS messages**  For appointment reminders & messages. Email: \_\_\_\_\_

Medicare No.: \_\_\_\_\_ Ref. on card: \_\_\_\_\_ Expiry: \_\_\_\_\_

Health Fund: \_\_\_\_\_ Member No.: \_\_\_\_\_

Pension Card/Health Care Card Number: \_\_\_\_\_ Expiry: \_\_\_\_\_

DVA File No.: (if applicable) \_\_\_\_\_

Occupation: \_\_\_\_\_

► **Emergency Contact:**

Full Name: \_\_\_\_\_ Relationship to you: \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (Mobile) \_\_\_\_\_

► **Next of Kin**

Full Name: \_\_\_\_\_ Relationship to you: \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (Mobile) \_\_\_\_\_

► **Cultural Background:**

Knowing your cultural background can help us provide healthcare that meets your individual needs.

There may be Commonwealth programmes that can assist us in your healthcare.

Are you of Aboriginal or Torres Strait Islander descent? (please tick)

No  Yes Aboriginal  Yes Torres Strait Islander  Yes both Aboriginal & Torres Strait Islander

Are you registered fo CTG?

Other Cultural Background (Mediterranean, Asian, African) \_\_\_\_\_

Country of Birth: \_\_\_\_\_ Religion: \_\_\_\_\_

Is English your first language? Yes  No

If not, do you require us to provide an interpreter? Yes  No  Please specify language \_\_\_\_\_

► **Allergies:** Nil Known

List Allergies & Intolerances to Medications	Describe your reaction

Do you have a usual Pharmacist? \_\_\_\_\_

**Current Medication:** \_\_\_\_\_

**Significant Health Problems, Current:** \_\_\_\_\_

**Significant Health Problems, Past:** \_\_\_\_\_

► **Social & Family History:**

Alcohol Intake: Nil  Yes  Days per week: \_\_\_\_\_ Drinks per day: \_\_\_\_\_

Smoking History: Non Smoker  Ex-Smoker  Smoker

► **Significant Family History:**

**Mother:** Diabetes  Hypertension  Heart Disease  Colon Cancer   
Stroke  Depression  Breast Cancer  Other  \_\_\_\_\_  
Mother Alive? Yes  No  Age of Death \_\_\_\_\_ Cause of Death \_\_\_\_\_

**Father:** Diabetes  Hypertension  Heart Disease  Colon Cancer   
Stroke  Depression  Breast Cancer  Other  \_\_\_\_\_  
Father Alive? Yes  No  Age of Death \_\_\_\_\_ Cause of Death \_\_\_\_\_

**Collection Statement and Privacy Consent**

*For the primary purpose of providing you with the best quality care, we need to collect personal information about you (including your health information and sensitive information). Your information will enable us to thoroughly assess, diagnose and provide appropriate treatment to you.*

*If you do not provide this information to us, we may not be able to treat you.*

The personal information which we collect will also be used for:

- ◆ administrative purpose;
- ◆ clinical information will be captured to facilitate the best possible treatment for your holistic health care.
- ◆ billing purposes (either directly or through an insurer or compensation agency);
- ◆ use within the practice with practice staff, other doctors for your ongoing treatment;
- ◆ disclosure to other doctors and health professionals outside the practice involved in your healthcare;
- ◆ research, quality assurance activities and teaching purposes where de identified information is used;
- ◆ In the case of insurance or compensation claim it may be necessary to disclose and/or collect information that concerns your return to work to an insurer, your lawyer and/or your employer;
- ◆ for follow up reminders/recalls which may be sent to you regarding your health care and management;
- ◆ disclosure legally required by law, such as notifiable disease;
- ◆ where you are unable to act on your own behalf due to a health condition, we may need to discuss your health information with relatives or emergency contacts, in order that you are provided with appropriate care;
- ◆ direct marketing purposes (you may opt-out of direct marketing at any time by notifying the Practice in a letter or email);

We do not disclose your personal information to overseas recipients or to any 3rd party contacts without patient written consent.

Our practice uses a reminder and recall system to help you maintain your health. The practice sends reminders by post, telephone or text messaging/sms for immunisations, procedures and other health reviews as well as recalling for abnormal results and follow up requested by consultants and hospital discharges.

Our full Privacy Policy is available on request in the waiting area and on our website. That policy provides guidelines on the collection, use, disclosure and security of your information. The Privacy Policy contains information on how you may request access to, and correction of, your personal information and how you may complain about a breach of your privacy and how we will deal with such a complaint.

► **Consent:**

Signature of Patient or Guardian \_\_\_\_\_

Print Name \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_\_

**Please notify us promptly of any changes in your contact details. Accurate contact details help us identify you and your medical records, and allows us to contact you promptly about tests and results.**

► **How did you hear about us?** (please tick)

Advertisements: Local Newspaper  Letter Box Drop  Billboard

Advertising/Sponsorship  Travelled past Practice (car/bus/walk)

Word of Mouth  Website Search  Family /Friend referral

Other:  (please specify) \_\_\_\_\_