Sandy Hill Medical Centre

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.

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

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

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

Please turn over

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 & Privacy Consent

For the primary purpose of providing you with quality health care, we need to collect personal information (including health and sensitive information). This enables us to thoroughly assess, diagnose and treat you. If you do not provide this information, we may be unable to provide appropriate care.

☐ I consent to this practice collecting, storing, and using my health information as required for my ongoing care, in line with the Privacy Act and RACGP Standards.

☐ I consent to being contacted for recalls/reminders (e.g. immunisations, check-ups).

☐ I consent to the practice contacting me via: ☐ SMS ☐ Phone ☐ Email

Use of AI Support Tools

☐ I understand this practice may use an RACGP-approved AI support tool during consultations to assist the doctor in providing safe and effective care.

☐ I consent to this tool being used as part of my care. I understand my doctor always makes the final decisions.

☐ I may withdraw this consent at any time by advising staff.

Billing & Fees

☐ I understand this practice operates primarily as a private billing clinic.
Fees are payable on the day of consultation.
Some services or patient groups may be eligible for bulk billing, as outlined in the Practice Fee Policy.

The full **Privacy Policy** is available on request at reception and on our website. It explains:
how your information is collected, used, disclosed and secured
how you may request access/correction
how to make a complaint about a privacy breach and how we handle such complaints.

▶ Consent & Acknowledgement

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)_____