# New Patient Information Form

Sandy Hill Medical Centre

**Please take a few moments to read and complete the following:**

| | | | |
|---|---|---|---|
| Title: | Surname: | | |
| Given Names: | | Preferred Name: | |
| Date of Birth: | | Sex: | |
| Street Address: | | Suburb and postcode: | |
| Home phone: | Work phone: | Mobile phone: | |
| Would you consent to SMS Reminders? YES ☐ NO ☐ | Would you consent to receive emails? YES ☐ NO ☐ | Preferred method of contact: Phone ☐ Email ☐ SMS ☐ | |
| E-mail: | | Occupation: | |
| ***Medicare No:*** | Ref no on card: | Expiry date: | |
| ***Commonwealth Seniors/Pensioner/ Health Care Card*** | No: | Expiry Date: | |
| Department of Veterans Affairs | No: | Expiry Date: | |

## *Next of Kin*

| Title: | Full Name: | Phone No: | Relationships: |
|---|---|---|---|
| | | | |

## *Emergency contact:*

| Title: | Full Name: | Phone No: | Relationships: |
|---|---|---|---|
| | | | |

**Do you identify as an Aboriginal and/or non-English speaking background? Yes / No If Yes, please specify:**

## *Smoking status (please circle):*

| | | |
|---|---|---|
| ***Non -smoker*** | ***Smoker***: How many per day? | ***Ex-smoker:*** When did you give up smoking? |

## *Current Alcohol Intake:*

| | | |
|---|---|---|
| Do you drink alcohol? Yes ☐ No ☐ | If Yes, how many days per week? | Standard drinks per day: |

Are you Diabetic? Yes ☐ No ☐

| | |
|---|---|
| When was your last Pap Smear? | Do you or have you had High Blood Pressure? Yes ☐ No ☐ |

**Allergies:** Any know allergies? Yes ☐ No ☐ Food, medication, etc. If Yes, please specify:

| ***Social status:*** | | |
|---|---|---|
| **Are you married?** Yes ☐ No ☐ | **De Facto?** YES ☐ NO ☐ | **Single?** YES ☐ NO ☐ |

| ***How did you find out about us? (Please circle)*** | | | | | | |
|---|---|---|---|---|---|---|
| Friend/Family ☐ | Flyers ☐ | Neighbours ☐ | Internet ☐ | Driving by ☐ | Newspaper ☐ | Other ☐ |

***Please complete if enrolling dependents under 18 years old***

| | | | |
|---|---|---|---|
| MC reference No: | Full Name: | DOB: | Male or Female |
| MC reference No: | Full Name: | DOB: | Male or Female |
| MC reference No: | Full Name: | DOB: | Male or Female |
| MC reference No: | Full Name: | DOB: | Male or Female |

**If your child has <u>allergies</u> please specify:**

**Information about fees:** The practice bulk bills patients during business hours. Weekend & Public Holiday consultations will incur some out of pocket cost, however ***Children and Pensioners will be Bulk Billed.***

Work Cover claims require a claim number. At the end of the consultation for a Workcover consultation the account is handed to the patient for you to facilitate payment via your claim agent. Full payment is required on day for Workcover claims that do not currently have a claim number. You are then able to follow this up with your claim agent.

EFTPOS facilities are available.

**Missed Appointments:**

If you are unable to keep your appointment, please notify us immediately. We require 2 hours' notice for cancellations or a fee will apply.

**Please read and sign your acknowledgement below:**

Patient consent: I understand that Sandy Hill Medical Centre (SHMC) is committed to protecting the privacy of individuals and their personal information in accordance with the *Privacy Act 1988* (Cth). My signature below indicates that I consent to SHMC collecting, using, disclosing, storing and disposing of my personal information for the purposes set out in SHMC Privacy Policy, including but not limited to the provision of medical services and treatment to me and to enable me to be attended by medical practitioners within SHMC; the release of relevant personal information to other health professionals to allow quality medical care; inclusion in a recall register to be advised of follow up visits, medical updates and health information; for the purposes of data research and analysis including conducting clinical trials and proactive screenings; and the release of relevant personal information to my employer or prospective employer, their authorised representative and their insurer in the case of a work related consultation or service only. I understand I may withdraw my consent for SHMC to use and disclose my personal information (except when legal obligations must be met).

| Name: | Signature: | Date: |
|---|---|---|
| | | |