

NEW PATIENT DETAILS



Dr: _____

TITLE: _____ FIRST NAME: _____ MIDDLE NAME: _____

SURNAME: _____

KNOWN AS (if different to first name): _____

DATE OF BIRTH: ____ / ____ / ____

SEX: Male/Female

Are you registering as a **new patient** or **visitor** (Circle which applies)

MEDICARE NO: _____ REFERENCE: (No. beside your name) _____ EXPIRY: _____

ARE YOU OF ABORIGINAL AND/OR TORRES STRAIT ISLANDER ORIGIN?

(answering this question (if relevant) is medically beneficial to you and your ongoing health care)

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

If Yes: Have you previously registered for Closing The Gap: Yes No

Ethnicity: _____

RESIDENTIAL ADDRESS: _____

Postcode _____

POSTAL ADDRESS (if different from above): _____

Postcode _____

PHONE: (H) _____

(W) _____

MOBILE: _____

I consent to receive SMS reminders Yes No

EMAIL: _____

I consent to receive Practice Information via email Yes No

MARITAL STATUS: _____

COUNTRY OF BIRTH: _____

OCCUPATION: _____

EMPLOYER: _____

NEXT OF KIN: _____

RELATIONSHIP: _____

PHONE: _____

ALTERNATE EMERGENCY CONTACT:- _____

RELATIONSHIP: _____

PHONE: _____

PRIVATE HEALTH FUND: _____ LEVEL OF COVER: _____

PENSION NO: _____ EXPIRY _____

HCC NO: _____ EXPIRY _____

VET AFFAIRS NO: _____ GOLD OR WHITE CARD

Patient Consent: James Street Medical Centre requires your consent to collect personal information about you. Please read the consent form on the other side carefully, and sign where indicated below.

Signature of Patient: **Date:**

Print name and signature of Parent /Guardian (if under 18):

..... (PTO)

Patient Consent

James Street Medical Centre requires your consent to collect personal information about you. Please read this consent form carefully, and sign overleaf.

This Medical Practice collects such information for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history to allow us to properly assess, diagnose, treat and advise on all your health care needs.

⊖ I give my permission for my personal health information to be used for administrative purposes to assist in the running of James Street Medical Centre, including disclosure to others involved in my healthcare, such as treating doctors and specialists within and outside this Medical Practice. This may occur through referral to other Doctors, or for medical tests and in the reports or results returned to my doctor following referrals.

⊖ I give my consent for disclosure for research and quality assurance activities to improve individual, community health care and Practice management. This may occur when the Practice incorporates patient health records into de-identifiable patient information to transfer to a third party, normally used for quality improvement projects. De-identifiable patient information cannot be traced back to the individual.

⊖ I give my consent for my personal health records to be used for identifiable patient health information. This may occur when the Practice participates in research activities on behalf of a university as part of professional development activities to be collected. Identifiable patient information can possibly be traced back to the individual.

⊖ I give my consent to the presence of a third party to be present during my consultation. This may include a Practice Nurse or medical student.

⊖ I give my consent to be part of the Practice's National, State and Territory recall and reminder systems.

⊖ I give my consent to be contacted via SMS for appointment reminders.

⊖ I give my consent to receive emails containing information regarding my health when I request it. I also consent to receiving emails regarding General Health and Practice Information. (Please note the unlikely risks associated with electronic communication in that the information could be intercepted or read by someone other than the intended recipient).

⊖ I give consent for vaccines to be given as requested by the doctor.

⊖ I give consent to having procedures/excisions performed as discussed with my GP.

I understand that by signing the consent, I give authority to the Practice, on my behalf to use my relevant personal health information and I am free to withdraw my consent at any one time by verbal or written notification.

Signature of patient: _____

(To be completed if patient does not speak English).

I _____ (name) translated the above information to _____ (name of patient) and they have signed above. _____ (Name of patient) understands the Practice is authorised on their behalf to use their relevant personal information and they are free to withdraw their consent at any one time by verbal or written notification.

Past Medical History

Thank you for taking the time to complete this past medical history. This information is kept confidential between you and your Doctor and Practice Nurse, and helps the doctor quickly identify any particular health issues.

Name: _____

Date of Birth: _____

Allergies: _____

Do you identify as any of the following groups: Aboriginal and or Torres Strait Islander Yes ___ No ___

Do you identify as any of the following groups: Heterosexual ___ Gay/Lesbian ___ Bisexual ___

Any Personal Medical History or Family History Please provide details of the following.

Condition	Yes	No	Details	Family History
High Blood Pressure				
Diabetes				
Heart Problems				
High Cholesterol				
Cancer: Breast Bowel Prostate Other				
Asthma				
Epilepsy				
Kidney Disease				
Liver Disease Inc Hepatitis				
Depression/Mental Illness				
Other				

Previous Health History:

Operation/Hospitalisation	Year	Comments

Current Medications: (or bring in boxes/list)

Medication	Dose & Frequency	Time Last Taken

Immunisations:

Type	Yes	No	Date
Flu			
Tetanus			
Pneumovax			
Hep A or & Hep B			
Other			

Smoking, Alcohol, Drug Intake:

	Yes	No	Details
Do you smoke			No. Per day:
Ever smoked			Year Ceased:
Alcohol intake			Drinks per day:
Other Drugs			

Data Entry Completed

Doctor Initials: _____

Practice Nurse Initials: _____