New Patient Details

Please complete the details below to ensure we have your current information on record:

Kallangur MEDICAL CENTRE

Title: | O Mr | O Mrs | O Miss | O Master | O Dr | O Other_____

Surname :_____

First name :_____ Middle name:_____

Date of Birth :_____/_____/_____

Sex : | O Female | O Male | O Other|

Ethnicity: :_____

ATSI Status : | O Aboriginal | O Torres Strait Islander | O Both | O Neither|

Address :_____

Suburb :_____ State:_____ Post Code:_____

Home phone :_____

Work phone :_____

Mobile phone :_____

Do you consent to an appointment SMS reminder? | O Yes | O No |

Email address:_____

Medicare Card Number: _____ Reference number:_____ Expiry: ____/_____

| O Pension | O Health Care Card | Number:_____ Expiry:____/____/_____

DVA | O White | O Gold | Number:_____ Expiry:____/____/_____

Health Insurance Fund:_____ Health Insurance Number:_____

Religion :_____

Occupation :_____

Emergency Contact : _____

Relationship to patient :_____ Contact:_____

Medical History:

Any known **Allergies**? _____**Reaction:**_____**Severity:**_____

Height _____ Weight: _____ Waist measurement:_____

Mother Alive? Yes ☐ No ☐ If no, what was the cause of death? _____

Father Alive? Yes ☐ No ☐ If no, what was the cause of death? _____

Significant Family History: (Please tick if)

Mother: Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke ☐ Colon Cancer ☐ Depression ☐ Breast Cancer ☐

Father: Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke ☐ Colon Cancer ☐ Depression ☐

(Please Circle) Smoking? Ex Smoker- Year Stopped _____ Smoker- How many per day?_____ Or Non Smoker

How often do you drink alcohol? Never ☐ Yes, Days per week? _____ / Standard drinks per day? _____

P.T.O →

Kallangur
MEDICAL CENTRE

(Please circle) Marital Status: Single/Married/Defacto/Separated/Widowed/Divorced

(Please Circle) Accommodation: Own home/Relatives/Nursing Home/ Hotel/ Homeless

(Please Circle) Living with: Spouse/Relative/Friend/Alone

I acknowledge and consent that,

My personal details on this form will be shared between this practice, the Department of Human Services and the department of Health and Ageing. The information provided in this form is complete and correct.

Signature_____ **Date**_____/_____/_____

Health Information Collection and Use Consent Form

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 may properly assess, diagnose, treat and be proactive in your health care needs.

We aim to protect the 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 though referral 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 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 ☐

OR

I am unsure and would like to discuss this further with someone from the medical practice before I sign. ☐

Signed_____ **Date:** __/__/____