New Patient Details

KALLANGUR MEDICAL CENTRE

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

Title: ☐ Mr / ☐ Mrs / ☐ Ms / ☐ Miss / ☐ Master / ☐ Dr / ☐ Other _____

Surname :_____

First name :_____ Middle name:_____ Preferred name:_____

Date of Birth : _ _/_ _/_ _ _ _ Birth Sex: ☐ Female ☐ Male ☐ Other _____

Gender Identity: □ Female □ Male □ Other _____

Pronouns: □ She □ He □ They or Other: _____

Are you Australian : YES / NO or Other/Country of Origin:_____

ATSI Status : ☐ Aboriginal / ☐ Torres Strait Islander / ☐ Both

Address : _____

Suburb : _____ State:_____ Post Code: _ _ _ _

Home phone : _____

Work phone : _____

Mobile phone : _____

Do you consent to an SMS reminder for: Appointments? ☐ Yes / ☐ No For clinical reminders? ☐ Yes / ☐ No

Clinical communication (Results,clinical messages, e-scripts) ☐ Yes / ☐ No Health awareness info ☐ Yes / ☐ No

Email address: _____

Medicare Card No : _ _ _ _ _ _ _ _ _ _ Reference No: _ (Left of name of card) Expiry: _ _/_ _ _ _

☐HealthCare Card / ☐ Pension No: _ _ _ _ _ _ _ _ _ _ Expiry: _ _ /_ _ /_ _

DVA - Gold or white card No:_____ Expiry : _ _/_ _/_ _ _ _

Health Insurance Fund: _____ Health Insurance Number: _____

Religion : _____

Occupation : _____ OR Unemployed _____

Next of Kin: _____

Relationship to patient :_____ Contact Ph:_____

Emergency Contact person: _____ or Mark as 'as above' if same as Next of Kin

Relationship to patient : _____ Contact Ph: _____

Please be aware that scripts for some medications eg S4 and S8 drugs may not be prescribed by Doctor on your first few consultations and may require information regarding these medications from your previous GP or specialist

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) OR Adopted Y / N

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

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

(Please circle) Non-smoker / Smoker – how many per day? ___ / Ex-smoker – year stopped? _____

(Please circle) Do you drink alcohol? Never ___ / Yes – days per week? ___ / Standard drinks per day? ___

(Please circle) Marital Status: Single / Married / De-facto / Separated / Widowed / Divorced

(Please Circle) Accommodation: Own home / Relatives / Rental / Retirement village / Hostel/ Homeless

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

How did you find out about us? _____

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. We require your consent to collect personal information about you and use the information you provide in the following ways.

- 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. ☐

Signed _____ Date ___/___/___