**New Patient Form**

We are committed to providing you with the best care. Please help us to keep your health record up to date and accurate.

|  |  |
| --- | --- |
| Title: | Mr Mrs Ms Miss Master Other |
| Surname: |  |
| First Name: |   Middle Initial: |
| Preferred Name: |   Date of Birth: / / |
|  Street Address: |  |
| Postal Address (if different to street address) |  |
|  Mobile Ph: Work Ph: Home Ph: |
| Medicare Number: |   IRN: Expiry: / / |
| Private Health Pension/HCC No: Please tick card type: | Health Fund: Membership No:  Expiry: / / Pension Concession Card Health Care Card Commonwealth Seniors Card  |
| DVA No and Colour |  Gold White Lilac Orange  |
| Occupation |  |
| Head of Family:(persons under 17)  | Self OR Name: Relationship : Phone:  |
| Next of Kin  | Name: Relationship: Phone: |
| Emergency Contact | Tick if same as Next of Kin OR: Name: Relationship Phone:  |
| Email address |  |

**Australia is a genuinely multicultural society. To tailor appropriate care, encourage understanding and appreciation between people from different nationalities and backgrounds – Do you identify as someone form an ethnic or cultural background?**

 Yes – Please elaborate \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you require an interpreter? Yes No If so, what language? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**To assist with health initiatives – do you identify as Aboriginal or Torres Strait Islander?**

Yes - Aboriginal Yes - Torres Strait Islander No

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medical history: Do you have any of the following conditions/diseases?**

|  |  |  |
| --- | --- | --- |
|  Asthma |  Hepatitis |  Thyroid conditions |
|  Emphysema/COPD |  Peptic Ulcer |  Diabetes/Gestational Diabetes |
|  Tuberculosis |  Gout |  Cancer of any type |
|  Heart Disease/Heart Attack |  Osteoporosis |  Anaemia |
|  Stroke |  Dermatitis/Eczema |  Abnormal pap smear |
|  High Blood Pressure |  Psoriasis |  Anxiety |
|  High Cholesterol |  Dementia |  Depression |
|  Glaucoma |  Migraines |  Schizophrenia |
|  Blood Clots |  Seizures/Fits |  Bipolar |

Any other condition not listed above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list any regular prescribed medications** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list any over the counter medications (this includes vitamins, minerals, herbal remedies)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have any medication/food/dressing allergies?** Yes(please list below**)**  No

**Medication/food/dressing** **Side effect/allergic response**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Women only:**

**Date of last Cervical Screening \_\_\_\_\_\_/\_\_\_\_\_\_\_ Result:** Normal OR Abnormal(please circle)

**Immunisation – have you had any of the following immunisations?**

Tetanus Booster Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Don’t Know Haven’t had one

Hepatitis A Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Don’t Know Haven’t had one

Hepatitis B Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Don’t Know Haven’t had one

Pneumococcal Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Don’t Know Haven’t had one

Influenza Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Don’t Know Haven’t had one

Polio Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Don’t Know Haven’t had one

MMR Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Don’t Know Haven’t had one

Typhoid Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Don’t Know Haven’t had one

Rabies Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Don’t Know Haven’t had one

Chickenpox Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Don’t Know Haven’t had one

Meningococcal B Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Don’t Know Haven’t had one

**Child Immunisation –**

If completing for a child, are their immunisations up to date? Yes No

**Family history:**

Have any members of your family been diagnosed with or suffered from (please list person’s relationship to you):

 Diabetes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Asthma: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Heart Disease: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Mental Illness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Cancer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Conditions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History:**

 Tobacco: I have never smoked

 Tobacco: Ceased smoking: \_\_\_\_/\_\_\_\_/\_\_\_\_\_ OR I smoke \_\_\_\_\_\_\_\_ cigarettes per day/week

 Alcohol: I do not drink alcohol

 Alcohol: I consume \_\_\_\_\_ drinks per day, \_\_\_\_\_days per week

 Alcohol: I consume \_\_\_\_\_ drinks per week/month

 Alcohol: How often would you drink more than 6 drinks per day? \_\_\_\_\_\_\_\_\_\_

**Height: \_\_\_\_\_\_\_\_**cm  **Weight: \_\_\_\_\_\_\_**\_kg **Waist Measurement:** \_\_\_\_\_\_\_cm

**How often do you exercise OR engage in physical activity for 30 minutes or more?**

 Daily \_\_\_\_\_ times per week Never Other \_\_\_\_\_\_\_\_\_\_\_\_\_

**Social/Family Structure:**

Marital status

 Married Defacto Single Widowed No. of children: \_\_\_\_\_\_\_\_\_\_\_

C

C

Who lives at home with you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you a carer for someone? Yes No *OR* Is someone a carer for you? Yes No

**Consent**

Our surgery requires the above information to maintain your records electronically. This form will be scanned into your patient file and securely stored. I give permission for my personal health information to be used for administrative purposes to assist in the running of this practice, this includes disclosure to others involved in your healthcare, such as treating Doctors 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.

**Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Communication/ Reminder Consent Form**

**SMS Reminders and Notifications**

I consent to the practice contacting me by text message for the purpose of health promotion, practice news, appointment reminders, and to advice of Doctors running behind schedule and any follow-ups if required.

**I acknowledge that appointment reminders and follow- up reminders by text are an additional service and that they may not be sent on all occasions and that the responsibility for attending appointments, cancelling them and calling for results still rests with me.**

I understand I can cancel the text message facility at any time.

Text messages are generated using a secure facility and I understand that they are transmitted over a public network onto a personal telephone and as such may not be secure. However, the practice will not transmit any information which would enable an individual patient to be identified e.g. only first names will be used.

**Email Reminders**

I consent to the practice contacting me by email for the purpose of health promotion, health reminders, practice news and general follow ups for preventative care.

Emails are generated using a secure facility but I understand that they are transmitted over the internet and as such may not be secured. However, the practice will not transmit any information which would enable an individual patient to be identified. I understand I can cancel the email facility at any time.I understand that any SMS text message and email I forward to the practice are transmitted over public phone networks and the internet and may be intercepted and not reached the practice.

**Personal Information**

This information will be scanned into your health record. Personal information retained in your file is stored in a secure data area and treated as highly confidential.

|  |  |  |  |
| --- | --- | --- | --- |
| Patient full name |  | Date of Birth |  |
| Address |  |
| Mobile Phone Number  |  |
| Email Address  |  |

I have read the information both the Email and SMS Reminders/Notifications consent form and agree to the terms and conditions listed on page one. I give permission to be contacted by SMS and email.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent to Participate in Register, Recall and Reminder Systems**



I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ give my consent to participate in Practice, State and

National Register, Recall and Reminder programs.

*I understand that I can have my name removed from this register at any time.*

**OR**:

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_guardian/representative of

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_give my consent for them to participate in Practice, State and National Register, Recall AND Reminder programs.

I understand that this practice will contact me (the patient or my representative) to advise results and preventative care activities.

*I understand that I can have the patients name removed from this register at any time.*

**Please tick the applicable box and sign the consent form.**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship (if applicable):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For Women re: PAP Smears**

*Consent for Glover Street Surgery to receive previous pap smear results*

**

 I\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ give my consent for Glover Street Surgery to receive my previous pap smear results from the Pap Smear Register.

**OR**:

 I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ don’t give my consent for Glover Street Surgery to receive my previous pap smear results from the Pap Smear Register.

**Please tick the applicable box and sign the consent form.**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_