NEW PATIENT DETAILS

Dr: ___________________________

PRONOUN:________ FIRST NAME: _______________________ MIDDLE NAME:____________________________

SURNAME: ___________________________ KNOWN AS (if different to first name): _______________________

DATE OF BIRTH: _____ /_____/ _____ GENDER AT BIRTH: Male/Female GENDER IDENTITY: _______________

Are you registering as a <u>new patient</u> or <u>visitor</u> (Circle which applies)

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

PENSION NO: __________________________ EXPIRY ______________

HCC NO: ______________________________ EXPIRY ______________

VET AFFAIRS NO: ______________________ GOLD OR WHITE CARD

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

As Australia is a genuinely multicultural society, and to tailor appropriate care, encourage understanding and appreciation between people from different nationalities and cultures - do you identify as someone from a culturally and/or linguistic diverse background?
☐ No ☐ Yes - Please elaborate_____________________ *If yes, do you require an interpreter service?* ☐ No ☐ Yes

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: _____________________

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.

θ 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.

θ 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.

θ 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.

θ 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.

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

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

θ 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).

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

θ 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 __ Both__

Do you identify as any of the following groups: Heterosexual/Gay /Lesbian/Bisexual/Transgender/Intersex/Queer/Asexual

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: _______