NEW PATIENT INFORMATION FORM

We are committed to providing our patients with the best care. To do this it is essential that your health record is kept up to date and accurate.

SECTION 1:

Could you please assist us by completing the following:

Title – Please tick	☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master ☐ Other:		
Surname			
First Name			
Preferred Name			
Date of Birth			
Birth Sex	☐ Male ☐ Female		
Gender Identity - Please tick	☐ Male ☐ Female ☐ Non-binary ☐ Gender Diverse ☐ Transgender		
Pronouns	☐ He/Him/His ☐ She/Her/Hers ☐ They/Them/Theirs		
Ethnicity (eg: Australian)			
Street Address			
Suburb		**Postcode**	
Postal Address (if different)			
Home Phone			
Work Phone			
Mobile Phone			
Email			
Medicare Number		**Expiry Date**	
Medicare Card Line Number			
DVA Card No.		**Colour**	
Pension/Health Care Card		**Expiry Date**	
Preferred Chemist			
Next of Kin	**Name:** **Telephone Number:** **Relationship to patient**:		
Emergency Contact	**Name:** **Telephone Number:** **Relationship to patient:**		

Reminder Systems:

Our practice provides our patients with preventive care and early case detection reminders e.g. immunisations, annual health checks, skin checks and pap smears (Cervical Screening Test).

Do you wish to have any relevant health reminders sent to you?

☐ Yes – mail ☐ Yes – email at this address: ……

If we need to contact you what is your preferred method of contact:

☐ Home phone ☐ Mobile phone ☐ Mail

To assist with health initiatives - are you Aboriginal or Torres Strait Islander?

☐ Yes – Aboriginal ☐ Yes - Torres Strait Islander ☐ Yes - Aboriginal & Torres Strait Islander ☐ No

Do you require the services of a translator?

☐ Yes ☐ No

Do you have any allergies or are you sensitive to drugs or dressings: ☐ Yes (If yes please list below) ☐ No

Item:	**Reaction:**	**Severity:** (Mild, Moderate, Severe)

Current Medications:

_____

_____

_____

SECTION 2:

Your Past Health History:

Do you have or have you had any of the following?

☐ Operations (please list)_____

☐ Asthma

☐ Diabetes

☐ Hypertension

☐ Chronic Illness _____

☐ Other

_____

Immunisations:

Have you had any of the following immunisations? (Please tick one box only and list date if known)

Tetanus Booster	☐ Yes. Date:	☐ No	☐ Don't Know
Hepatitis B	☐ Yes. Date:	☐ No	☐ Don't Know
Hepatitis A	☐ Yes. Date:	☐ No	☐ Don't Know
Influenza	☐ Yes. Date:	☐ No	☐ Don't Know
Pneumococcal	☐ Yes. Date:	☐ No	☐ Don't Know

_____

Children's Immunisations:

If completing this form for a child are their immunisations up to date?

☐ Yes ☐ Copy provided to Practice

☐ No

_____

Family History:

Is your Mother Alive: ☐ Yes ☐ No

Is your Father Alive: ☐ Yes ☐ No

Unknown: ☐ Adopted ☐ No Significant Family History

Has your mother ever had: (please elaborate)

Mother: ☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke
☐ Asthma ☐ Mental Illness ☐ Cancer – Type: _____

Has your father ever had: (please elaborate)

Father: ☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke
☐ Asthma ☐ Mental Illness ☐ Cancer – Type: _____

Other Family Members: _____

Social History:

Do you use any of the following: (list amount where appropriate)

Tobacco ☐ No
☐ Yes. Number per day: _____ Year Started: _____
☐ Ceased Smoking

Alcohol ☐ No – Non Drinker
☐ Yes. How many standard drinks per day: _____
How many days per week would you consume alcohol: _____

Drug Use ☐ No
☐ Yes. Type _____ Frequency _____

Occupation: _____

Are you exposed to any of the following:

☐ Asbestos ☐ Radiation ☐ Dust ☐ Animals ☐ Other: _____

Sun Protection:

How often do you use the following to protect yourself from the sun when outdoors?

Protective Clothing	☐ Always	☐ Often	☐ Sometimes	☐ Rarely	☐ Never
Sunscreen Creams	☐ Always	☐ Often	☐ Sometimes	☐ Rarely	☐ Never

Females:

Cervical Screenings:

Is your Cervical Screening (Pap Smear) up to date (last Screening must have been in the last 5 years): ☐ Yes ☐ No

When was your last recorded Cervical Screening (e.g.: what year): _____

Result, if known: ☐ Negative ☐ Unknown ☐ Other: _____

Please indicate if you would like to be contacted about booking in for a Cervical Screening: ☐ Yes ☐ No

Breast Check:

When did you last have a Breast Check

Date: _____ ☐ Not sure ☐ Never

Please indicate if you would like to be contacted about booking in for a Breast Check: ☐ Yes ☐ No

Males:

When did you last have an Overall Checkup?

Date: _____ ☐ Not sure ☐ Never

Signature of New Patient/Guardian: _____

Health Information Collection and Use Consent Form

Patrick Street Family Practice
Suite 1, 8-22 Patrick Street
Stawell VIC 3380

P: (03) 5358 7555
F: (03) 5358 1669
E: enquiries@psfamprac.com.au

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 accreditation, 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, disclosures as required by the court of law.
- For reminder letters which may be sent to you regarding your health care and management.
- To allow medical students and staff to participate in medical training/teaching using only de-identified information.

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 have read the information above and understand the reasons why my information must be collected.	☐
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.	☐

Patient's Name: _____ **Date:** _____

Patient's Signature: _____

Signed as Guardian for child: _____

Name: (printed) _____

Office Use Only

☐ Received Date: _____ Initial: _____

☐ Scanned Date: _____ Initial: _____

☐ Section 1 Entered (by Admin Staff) Date: _____ Initial: _____

☐ Section 2 Entered (by Clinical Staff) Date: _____ Initial: _____