



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 contains complete and accurate information. Please assist us by completing your new patient information form.

PATIENT DETAILS

Title	_____			Preferred Name:	_____
First Name:	_____			Surname:	_____
Sex at Birth:	_____			Gender Identity:	_____
Pronouns:	☐ She/her/hers ☐ He/him/ ☐ They/them/theirs ☐				
Date of Birth:	_____				
Street Address:	_____				
Suburb:	_____		State:	_____	Postcod
Postal Address (if different to above):	_____				
Subur	_____		State:	_____	Postcod
Mobile	_____				
Ema	Alternative Contact: _____				

CULTURAL IDENTITY

Do you identify as Aboriginal and/or Torres Strait Islander? ☐ No

☐ Yes, Aboriginal ☐ Yes, Torres Strait ☐ Yes, Aboriginal and Torres Strait

Country of Birth: _____ Ethnicity: _____

Preferred Language: _____ Do you require an _____ ☐ ☐ No

HEALTHCARE IDENTIFIERS

Medicare Card Number:	_____	Re	Expiry:	_____
Dept. of Veterans Affairs File	_____		☐ Gold ☐ White	
Pension Card Number:	_____		Expiry:	_____
Healthcare Card Number:	_____		Expiry:	_____



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NEXT OF KIN

Full _____ Relationship to you: _____
Mobile Phone: _____ Alternative Contact: _____

EMERGENCY CONTACT

Full _____ Relationship to you: _____
Mobile Phone: _____ Alternative Contact: _____

YOUR HEALTH INFORMATION

Allergies ☐ No ☐ Yes – list and provide reactions

Current Medications – please list all your current medications, including complementary and over-the-counter medicines (i.e. homeopathic medicines such as

Medical History – do you have or have you had a history of the following:

- ☐ Surgery – provide details:
- ☐ Asthma
- ☐ Diabetes
- ☐ Hypertension
- ☐ Chronic Illness
- ☐ Cardiovascular Disease
- ☐ Other – provide details:



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Do you smoke or vape?

- ☐ No ☐ Ceased – Year _____ Year
- ☐ Yes – Year Started: _____ Quantity per _____

Do you drink alcohol?

- ☐ No ☐ Yes – Days per Week: _____ Number of Standard Drinks per _____

Do you use recreational drugs?

- ☐ No ☐ Yes – Type: _____ Frequency: _____

FAMILY HEALTH HISTORY INFORMATION

Have any of your family members had:

- ☐ Cardiovascular Disease
- ☐ Asthma
- ☐ Diabetes
- ☐ Hypertension
- ☐ Mental Illness
- ☐ Cancer – provide _____
- ☐ Other – provide details: _____



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Patient Consent

Please read this consent form carefully prior to signing.

This general practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose and treat illnesses and medical conditions, ensuring we are proactive in your health care. To enable ongoing care, and in keeping with the *Privacy Act 1988* and *Australian Privacy Principles*, we wish to provide you with sufficient information on how your personal information may be used or disclosed and record your consent or restrictions to this consent.

Your personal information will only be used for the purposes for which it was collected or as otherwise permitted by law, and we respect your right to determine how your information is used or disclosed.

The information we collect may be collected by a number of different methods and examples may include: medical test results, notes from consultations, Medicare details, data collected from observations and conversations with you, and details obtained from other health care providers (e.g. specialist correspondence).

By signing below, you (as a patient/parent/guardian) are consenting to the collection of your personal information, and that it may be used or disclosed by the practice for the following purposes:

- Administrative purposes in the operation of our general practice.
- Billing purposes, including compliance with Medicare requirements.
- Follow-up reminder/recall notices for treatment and preventative healthcare, frequently issued by SMS.
- Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals.
- Accreditation and quality assurance activities to improve individual and community health care and practice management.
- For legal related disclosure as required by a court of law.
- For the purposes of research only where de-identified information is used.
- To allow medical students and staff to participate in medical training/teaching using only de-identified information.
- To comply with any legislative or regulatory requirements, e.g. notifiable diseases.
- For use when seeking treatment by other doctors in this practice.



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At all times we are required to ensure your details are treated with the utmost confidentiality. Your records are very important and we will take all steps necessary to ensure they remain confidential. Please complete the form below if you understand and agree to the following statements in relation to our use, collection, privacy and disclosure of your patient information.

Our practice may communicate with patients via email for administrative purposes (including appointment reminders and practice information). And, where appropriate, for clinical correspondence. Where emails contain personal or health information the practice will take reasonable steps to protect your privacy. This may include sending documents as password-protected attachments, with the password provided separately. Despite these precautions, you acknowledge that email is not a completely secure method of communication and that there is a risk that information transmitted electronically may be accessed by unauthorized persons. By providing your email address and signing this form you consent to: the practice contacting you via email, the transmission of your personal and health information by email where clinically or administratively appropriate and receiving documents containing personal or medical information via password-protected email attachments. You are responsible for ensuring that the email address provided is correct and that only authorized persons have access to your email account. You may withdraw your consent to email communication at any time by notifying the practice. Email communication is monitored intermittently during business hours and must not be used for urgent or emergency medical matters. Please note: clinical questions or requests cannot be attended to via email – an appointment must be made to discuss clinical issues with your doctor.

I, _____ have read the information above and understand the reasons why my information must be collected, and the purposes for which my information may be used or disclosed. I understand that if my information is to be used for any purpose other than that set out above, my further consent will be obtained.

I, _____ give permission for my personal information to be collected, used and disclosed as described above, including contact via SMS to my mobile phone number and email. I understand only my relevant personal information will be provided to allow the above actions to be undertaken and I am free to withdraw, alter or restrict my consent at any time by notifying this practice in writing.

Signed _____

Date _____