

New Patient Information Form

We are committed to providing our patients with the best care, to do this it is essential that your medical records are up to date and accurate.

*FIRST NAME		KNOWN AS	
*SURNAME		MRS / MS / MR / MISS / NON-BINARY	
*DATE OF BIRTH			
*MEDICARE NUMBER		Ref No.	Expiry Date / /
*DVA Gold / White Number: <i>Please circle</i>		Expiry Date / /	
* Health Care Card / Pension Card Number: <i>Please Circle</i>		Expiry Date / /	
*RESIDENTIAL ADDRESS			
*POSTAL ADDRESS			
*HOME PHONE		*WORK PHONE	*MOBILE PHONE
*EMAIL			
*MARITAL STATUS			
*OCCUPATION			
*COUNTRY OF BIRTH		CITIZENSHIP	*ORIGIN OF ANCESTRY

DETAILS OF YOUR NEXT OF KIN AND EMERGENCY CONTACT

*NAME	IS THIS PERSON YOUR EMERGENCY CONTACT <input type="checkbox"/> YES <input type="checkbox"/> NO
*RELATIONSHIP TO PATIENT	
*ADDRESS	
*PHONE NUMBER	

DO YOU REQUIRE AN INTERPRETER Yes ☐ No ☐

TO ASSIST WITH HEALTH INITIATIVES:

Do you identify as an Aboriginal? Yes ☐ No ☐

Do you identify as a Torres Strait Islander? Yes ☐ No ☐

Do you currently have private health insurance? Yes ☐ No ☐

Name of Provider _____ Membership Number _____

Reminder Systems:

Our practice participates in the National / State / Territory reminder system and provides our patients with preventive care and early case detection reminders, e.g. immunisations, annual health checks, skin checks and pap smears.

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

Yes

☐

No

☐

Are you happy to be sent an SMS appointment reminder?

Yes

☐

No

☐

Your Health History – PLEASE INCLUDE AS MUCH DETAIL AS POSSIBLE ON ALL OPERATIONS, PROCEDURES AND MEDICAL CONDITIONS SINCE YOU WERE BORN. IT IS VERY IMPORTANT THAT WE KNOW ALL YOUR MEDICAL HISTORY.

Do you have any allergies or are you sensitive to drugs or dressings:

Yes (If yes please list below)

☐

No

☐

Immunisations - Have you had the following immunisations? (Please List)

Tetanus booster Date_____

Don't Know

Haven't had one

Hepatitis B Date_____

Don't Know

Haven't had one

Shingles Date_____

Don't Know

Haven't had one

Influenza Date_____

Don't Know

Haven't had one

Pneumococcal Date_____

Don't Know

Haven't had one

Polio Date_____

Don't Know

Haven't had one

Children's Immunisations - If completing this form for a child, are their immunisations up to date?

Yes

☐

No

☐

Current Medications (including over the counter medications, vitamins and minerals)

Family History - Has any members of your family had? (Please List)

Diabetes_____

Asthma_____

Heart Disease _____
Mental illness _____
Cancer _____
Other _____

Social History

Tobacco: _____ day / week or Ceased Smoking –date ____/____/____

Alcohol: _____ day / week / month (circle the one applicable)

Drug use _____ (type and frequency)

Height: _____ cms Weight: _____ kgs

Blood Pressure: When was the last time your blood pressure was taken? ____/____/____

Females: When did you last have? (Please List)

Pap smear Date _____ not sure ☐ never ☐

Mammogram Date _____ not sure ☐ never ☐

Obstetric History

Please list details of previous pregnancies _____

Males: When did you last have?

An overall check up Date _____ not sure ☐ never ☐

Patients Signature or Parent / Guardian (if child is a minor)

_____ Date ____/____/____

Privacy Patient Information

To provide a high standard of medical care we need to collect personal information from our patients. This information is usually collected from the patient but may be collected from family members and other health care provider's with the patient's consent. At times some of this information needs to be shared with other health care providers or we may be legally bound to disclose personal information. All persons accessing your personal health information are bound by confidentiality. Please do not hesitate to discuss any concerns, questions or complaints about any issues related to the privacy of your personal information with your Doctor. If you require another member of your family to access your medical results of tests, this cannot be done without a consent form signed by the patient. Please ask our reception staff for this form if you require one. Thank You

PRIVACY ACT

PATIENT CONSENT

TO COLLECT & DISCLOSE INFORMATION

The Privacy Act 1988 requires medical practitioners to obtain consent from their patients to collect, use and disclose that patient's personal information.

Collection

This means we will collect information that is necessary to properly advise and treat you. Such necessary information may include:

- full medical history;
- family medical history;
- ethnicity;
- contact details;
- **medicare / private health fund detail**
- genetic information; and
- billing / account details
- Clinical images (photographs)

The information will normally be collected directly from you. There may be occasions when we will need to obtain information from other sources, for example:

- other medical practitioners, such as former GPs and specialists;
- other health care providers, such as physiotherapists, psychologists, pharmacists, dentists, nurses; and
- **Hospitals and Day Surgery Units**

Both our practice staff and the medical practitioners may participate in the collection of this information.

In emergency situations we may need to collect personal information from relatives or other sources where we are unable to obtain your prior express consent.

Use & Disclosure

With your consent, the practice staff will use and disclose your information for purposes such as:

- account keeping and billing purposes;
- referral to another medical practitioner or health care provider;
- sending of specimens, such as blood samples or pap smears, for analysis;
- referral to a hospital for treatment and / or advice;
- advice on treatment options;
- the management of our practice;
- quality assurance, practice accreditation and complaint handling;
- to meet our obligations of notification to our medical defence organisations or insurers
- to prevent or lessen a serious threat to an individual's life, health or safety; and
- where legally required to do so, such as producing records to court, mandatory reporting of child abuse or the notification of diagnosis of certain communicable diseases
- to make available your records to the on call doctor, for your medical treatment, when the need arises.
- to supply results / reports / recommendations to your referring doctor pertaining to your medical management.
- Our practice uses document automation technology so that only relevant medical information is included in your referral letters.

Conflict of Interest Information

We provide the following information on potential conflicts of interest. A conflict of interest exists when a person entrusted with the interests of a patient, other individuals or the public violates that trust by promoting their own interests or the interests of third parties. Conflicts of interest may be financial, professional, personal, ethical, moral or religious. A conflict of interest exists when such interests compromise known obligations and interfere with objective professional judgment. Doctors must resolve such conflicts in accordance with the best interests of the patient. Our doctors have relationships with numerous hospitals, pharmaceutical, medical device and service provision companies who rely on their expertise. Occasionally they serve on advisory boards, provide expert opinion and perform research for companies and institutions. Occasionally these activities are financially rewarded and many of our doctors, their families or their superannuation funds have financial interests in medical facilities including but not limited to Granite Belt Medical Services. Granite Belt Medical Services doctors always act in the patients' best interests when making referrals and providing or arranging care. We do not allow any financial or commercial interest in a hospital, other health care organization, or company providing health care services or products to affect the way in which we treat patients.

Access

You are entitled to access your own health records at any time convenient to both yourself and the practice.

Access can be denied where:

- to provide access would be a serious threat to your life or health;
- there is a legal impediment to access;
- the access would unreasonably impact on the privacy of another;
- your request is considered frivolous;
- the information relates to anticipated or actual legal proceedings and you would be entitled to access the information in those proceedings; and
- in the interests of national security.

Consent

I provide my consent for Granite Belt Medical Services to collect, use and disclose my personal information as outlined above. I provide consent for referrals and results to be sent to a medical specialist or doctor by facsimile.

I provide consent for messages to be left with immediate family members / defacto partner (e.g. appointment confirmation). I

understand that I am entitled to access my own health records except where access would be denied as outlined above.

I understand that I may withdraw my consent as to use and disclosure of my personal information (except when legal obligations must be met).

Print Name:

Signed by Patient:

February, 2022

Privacy Patient Information

To provide a high standard of medical care we need to collect personal information from our patients. This information is usually collected from the patient but may be collected from family members and other health care provider's with the patient's consent. At times some of this information needs to be shared with other health care providers or we may be legally bound to disclose personal information. All persons accessing your personal health information are bound by confidentiality. Please do not hesitate to discuss any concerns, questions or complaints about any issues related to the privacy of your personal information with your Doctor. If you require another member of your family to access your medical results of tests, this cannot be done without a consent form signed by the patient. Please ask our reception staff for this form if you require one. Thank You