New Patient form

Please complete ALL questions

Belmore Road Family Practice

12 Belmore Road,
Lorn 2320

Title: _____ First Names: _____

Surname: _____

Date of Birth: ___ /___ /_____ Gender: Male ☐ Female ☐ Transgender ☐

Address: _____ Suburb: _____Postcode: _____

Postal address (if different): _____ Suburb: _____ Postcode: _____

Phone: Home_____ Mobile_____ Work_____

Email: _____

Medicare No. _____ No. on card: _____ Expiry: _____

Concession: Pension ☐ Health Care Card ☐ Veterans Affairs ☐

Number: _____ Expiry: _____

Private Health Fund: Yes ☐ No ☐ Fund: _____

Number: _____ Type: Basic ☐ Intermediate ☐ Top ☐

Marital Status: Single ☐ Married ☐ Defacto ☐ Separated ☐ Divorced ☐ Widowed ☐

Occupation: _____ Country of Birth: _____

Spoken Language: English ☐ Other: _____ Interpreter Required: _____

Are you of Aboriginal or Torres Strait Islander origin? Yes ☐ No ☐

Aboriginal ☐ Torres Strait Islander ☐ Aboriginal and Torres Strait Islander ☐

Ethnicity - what country were your parents born? Mother: _____ Father: _____

(This information assists us to identify your risk/pre-disposition to certain diseases, illnesses and conditions, and enables us to offer appropriate preventative advice and or medical care).

Is there anything else you would like your Doctor to know about your cultural background or beliefs?

_____

Next of Kin: _____ Relationship to you: _____

Phone: _____ Mobile: _____ Work: _____

Emergency Contact: _____ Relationship to you: _____

Phone: _____ Mobile: _____ Work: _____

Allergies: No ☐ Yes ☐ Please list: _____

_____

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Medications and Medical History

Intolerances to Medications: No ☐ Yes ☐ Please list: _____

Please list reaction details: _____

Regular Medications (including over the counter vitamins and minerals): ☐ Yes ☐ No

If yes, please list names and dosages:

_____

_____

_____

Do you have a history of: Asthma ☐ Diabetes ☐ Hypertension ☐ Chronic Illness ☐

Other ☐ If other, please specify: _____

Is there a family history of: Asthma ☐ Diabetes ☐ Hypertension ☐ Chronic Illness ☐

Other ☐ If other, please specify: _____

Person's relationship to you with the above (eg. Mother – diabetes):

_____

Have you ever had any operations: Yes ☐ No ☐

If yes, please list: Operation: _____ Date: _____

Operation: _____Date: _____

Operation: _____ Date: _____

Operation: _____ Date: _____

Health

Do you currently smoke cigarettes: No ☐ Yes ☐

If no, have you previously smoked: No ☐ Yes ☐ When did you give up? ____ / ____ /____

If yes, how many cigarettes do you smoke daily? _____

How often do you have a drink containing alcohol? Never ☐ Monthly or less ☐

2-4 times month ☐ 2-3 times week ☐ 4 or more times a week ☐

How many standard drinks of alcohol would you have in a typical day?

1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 or 9 ☐ 10 or more ☐

How often do you have six or more drinks on one occasion?

Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily ☐

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Children's Immunisation (If completing form for a child)

Are their immunisations up to date? Yes ☐ No ☐

Consent for contact

I consent to being contacted by SMS for appointment reminders? Yes ☐ No ☐

I consent to being contacted by telephone for appointment reminders? Yes ☐ No ☐

I consent to being contacted by mail for appointment reminders? Yes ☐ No ☐

I consent to being contacted for preventative health care reminders?

By SMS	Yes ☐	No ☐
ByTelephone	Yes ☐	No ☐
By Mail	Yes ☐	No ☐

Belmore Road Family 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.

Your personal health 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.

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 healthcare and practice management
- For legal related disclosure as required by a court of law
- For the purpose of research and population health only where de-identified information is used
- To comply with any legislative or regulatory requirements, eg. 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.

Consent

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. I understand that 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 Belmore Road Family Practice in writing.

Patient name: (please print) _____

Signature: _____ **Date**: _____

If not patient signing – your name: (please print) _____

Your relationship to patient (eg. Mother, Father, Guardian) _____

TRANSFER OF HEALTH INFORMATION: You may have consistently consulted with a GP at another practice. The information held by that GP may assist with your future health care needs. You may wish to have a copy/summary of your health records transferred to this practice. Please ask the receptionist for information about how this can take place.

Our surgery participates in Digital Health/My Health Record. Your verbal permission will be asked at the time of uploading.