



ST KILDA SOUTH MEDICAL CLINIC

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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 record form. As you are providing us with health information please also read and sign a consent form to allow us to collect and use your health information.

Please tick Aboriginal Torres Strait Islander Refugee None

Family Name (Mr /Mrs/ Ms/ Miss)

Given Names Gender

Date of Birth

Address.....
(number) (street)

.....
(suburb) (postcode)

Telephone: (Home) (Work)

Mobile number (E-mail address)

Send confirmation SMS? YES NO

Country of Birth..... Year of arrival in Australia.....

Spoken Language..... Preferred Language

Any Religious Affiliation Ethnicity.....

Interpreter required?..... Any custody issues?.....

Current Occupation..... or School..... Year.....

Marital Status (circle): Single, Married, Engaged, Divorced, De facto, Have a partner, Widowed

Previous Doctor..... Address.....

Next of Kin:

Emergency Contact:

Full name.....

Full name.....

Home ph

Home ph

Mobile ph.....

Mobile ph.....

Relationship to patient.....

Relationship to patient.....

ACCOUNT DETAILS

Medicare Number Expiry Date.....

Medicare Reference No: the number beside your name on your Medicare card

Do you have private health insurance (cross in box) yes no

Pensioner Health Benefits Card

Health Care Card

Dept of Veterans Affairs

Other (specify e.g. TAC.)

I agree to pay all accounts within this practice's specified time period. In the event of late payment the Practice reserves the right to charge an accounting fee. Also I have been given a copy of the Practice brochure.

Signature.....

In order for you and your doctor to work together to achieve the best possible health outcomes, it is important that the doctor understands you as more than just a patient with an illness.

At this Practice, we would be grateful if you could complete the accompanying Patient Health Summary so that the doctor understands your physical, emotional, and social settings. With this information up to date, more appropriate appointments, treatments, investigations and follow up can be negotiated by you and your doctor to maximise your wellbeing.

MEDICAL HISTORY:

Do you have any allergies to medicines or anything else?) yes no

To what?..... Reaction.....

Current Medications (including over the counter medication):

| Name of Medication | Strength | Times Taken |
|--------------------|----------|-------------|
| | | |
| | | |
| | | |
| | | |

Have you ever had any major operations or been admitted to hospital?

| Year | Reason |
|------|--------|
| | |
| | |
| | |
| | |

Preventative Health

When was your last check for the following:

| | Year of onset | Active Now <input checked="" type="checkbox"/> | | Year of onset | Active Now <input checked="" type="checkbox"/> |
|---------------------------|---------------|--|--------------------------------|---------------|--|
| Heart Problems | | | Serious infections | | |
| Angina, Hypertension | | | Skin rashes, eczema, psoriasis | | |
| High Cholesterol | | | Migraine | | |
| Varicose veins, clots | | | Asthma/emphysema | | |
| Stomach ulcers | | | Hey fever/ sinus problems | | |
| Gall Stones | | | Eye/ear | | |
| Liver problems, Hepatitis | | | Back/Neck problems | | |
| Pancreatitis | | | Serious trauma | | |
| Diabetes | | | Prostate problems/impotence | | |
| Thyroid problem | | | Abnormal pap smear | | |
| Gout | | | Sexually transmitted disease | | |
| Arthritis | | | AIDS | | |
| Cancer | | | Intravenous drug use | | |

Immunisations:

| | Year | | Year | | Year |
|-----------|------|-----------------|------|-----------------|------|
| Birth | | Year 7 | | Meningococcal C | |
| 2 months | | Year 10 | | Measles | |
| 4 months | | Tetanus | | Typhoid | |
| 6 months | | Rubella | | Chicken Pox | |
| 12 months | | Hepatitis A | | Influenza | |
| 18 months | | Hepatitis B | | Pneumonia | |
| 4 years | | Meningococcal B | | | |
| | | | | | |
| | | | | | |

Family History:

| Has anyone related to you ever had | Relationship to you | Ever Had <input checked="" type="checkbox"/> | Age of onset | Died From /Age <input checked="" type="checkbox"/> |
|------------------------------------|---------------------|--|--------------|--|
| High blood pressure | | | | |
| High cholesterol | | | | |
| Heart attack/angina | | | | |
| Stroke | | | | |
| Anaemia | | | | |
| Bleeding disorder | | | | |
| Asthma/emphysema | | | | |
| Tuberculosis | | | | |
| Arthritis | | | | |
| Diabetes | | | | |
| Kidney disease | | | | |
| Cancer or tumour | | | | |
| Other | | | | |

Social

| | Yes <input checked="" type="checkbox"/> | No <input checked="" type="checkbox"/> | |
|-------------------------|---|--|-----------|
| Cigarette | | | Per day: |
| Alcohol | | | Per week: |
| Intravenous drugs | | | |
| Other drugs (marijuana) | | | |



Health Information Collection and Use Consent Form

Please read this consent form carefully prior to signing.

St Kilda South Medical Clinic 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.

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.

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 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.

Patient name: (please print) _____

Signature: _____ Date: _____

If not patient signing - your name (please print) _____

Your relationship to patient (e.g. Mother, Father, guardian) _____

PRACTICE USE ONLY:

Witnessed by: (staff signature) _____