CASEY MEDICAL CENTRE

DR TO INITIAL

NEW PATIENT INFORMATION FORM – (ADULT > 16yr)

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 & accurate.
Please assist us by completing the following.

MR MRS MS MISS MASTER DR (PLEASE CIRCLE) OTHER_____

SURNAME: _____

GIVEN NAMES: _____

PREFERRED NAME:_____ **SEX:**_____ **D.O.B:**_____/_____/_____

Do you identify as being of Aboriginal and / or Torres Strait Islander origin? Yes Both Neither (PLEASE CIRCLE)

If yes (ATSI) are you registered for "close The Gap" Program? Yes ☐ No ☐

IN WHAT COUNTRY WERE YOU BORN: _____**CUTURAL BACKGROUND/ETHNICITY** _____

LANGUAGE SPOKEN: _____ **Do you require an interpreter?** YES ☐ NO ☐

HOME ADDRESS: _____

POSTAL ADDRESS: (If different from home address): _____

EMAIL ADDRESS: _____

TELEPHONE NO: Home: _____**Work:** _____**Mobile:**_____

PATIENT'S MEDICARE NO: _____**REF NO:** _____**EXP DATE:** _____

PENSION/HCC TYPE: _____ **NUMBER:** _____ **EXP DATE:** _____

D.V.A. NO: _____ **Gold Card / White Card** (PLEASE CIRCLE) **EXP DATE:** _____

DVA CONDITION (If other than Gold Card): _____

CURRENTLY EMPLOYED: YES ☐ NO ☐ **OCCUPATION:** _____

NEXT OF KIN: _____**RELATIONSHIP:**_____

TELEPHONE NO: _____ **ALTERNATIVE TEL NO:** _____

EMERGENCY CONTACT: (if different to next of kin)_____

RELATIONSHIP:_____**TELEPHONE NO:** _____

MEDICAL DETAILS:

Do you have any current/ongoing medical problems?_____

_____

_____

_____

_____

Do you have any past medical problems which have resolved? (e.g. Past surgery) _____

_____

_____

_____

_____

Do you take any medications currently? (If so please list names and doses) _____

_____

_____

_____

Do you have any allergies, or are you sensitive to any medications or dressings? (If yes please list below) **YES** ☐ **NO** ☐

_____

_____

SOCIAL HISTORY:

☐ Tobacco: _____ day / week - Year started _____ year ceased (if applicable) _____

☐ Alcohol: _____ standard drinks per day / week / month (circle the one applicable)

☐ Drug use: _____ (type and frequency)

Height: _____ cms **Weight:** _____ kgs

Have you ever had a Chronic Disease Management Care Plan? (e.g. Allied Health, Physio etc) ☐ **Yes** ☐ **No**

If Yes please list (include date or year) _____

FAMILY HISTORY – Have any members of your family had any of the following?

☐ Diabetes: _____

☐ Asthma: _____

☐ Heart Disease: _____

☐ Mental illness: _____

☐ Cancer: _____

☐ Other: _____

Females: When did you last have?

Cervical Screening Test (previously called Pap smear) Date_____ ☐ not sure ☐ never

Breast Check Date_____ ☐ not sure ☐ never

Mammogram Date_____ ☐ not sure ☐ never

Males: When did you last have?

Prostate checkup (over 50 years) Date _____ ☐ not sure ☐ never

MY HEALTH RECORD: Having a 'My Health Record' means your important health information such as allergies, current conditions and treatments, medication, pathology reports or diagnostic imaging reports can be digitally stored in one place. Health care providers such as doctors, specialists and hospital staff are able to see this information online from anywhere at any time when they need to, such as in an accident or emergency. Your doctor may ask if you would like to create this record.

Reminder Systems:

- The practice routinely sends SMS appointment reminders as well as for recalls and test results.

  Please tick the box if you are happy to receive SMS (mobile text messages): ☐ **Yes** ☐ **No**

CASEYMEDICALCENTRE

Health Information Collection and Use Consent Form

As a patient of Casey Medical Centre 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:

- Administrative purposes in the running of our medical practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your health care including but not limited to hospitals, 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 research and quality assurance activities to improve individual and community health care and practice management. Usually information that does not identify you is used. However, if identifying information is 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.
- For reminder letters/SMS which may be sent to you regarding your health care and management. Please read this consent form carefully, and sign where indicated below.

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 and provide the best outcome for you.

PLEASE TICK CONSENT BOXES BELOW:

- ☐ 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 purposes set out above, subject to any limitations on access or disclosure about which I will 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]: Reception_____ DR _____