KILSYTH MEDICAL CENTRE

NNEW PATIENT INFORMATION FORM

Please help us to provide the best possible patient care by completing the following pages

** = This information is completely voluntary and may help individualise and enhance your care. Any information is strictly private and confidential*

TITLE	Mr Mrs Ms Miss Mst Other					
SURNAME		**FIRST NAME**				
DATE OF BIRTH	/ /	***GENDER**	☐ Male	☐ Female	☐ Prefer not to say	
ADDRESS						
		POSTCODE				
MAILING ADDRESS						
		POSTCODE				
PHONE NUMBERS	Mobile:	Home:	Work:			
MEDICARE CARD		REFERENCE No. (next to name)	EXP			
DVA NUMBER		☐ GOLD ☐ WHITE	EXP			
PENSION or HEALTHCARE CARD	CRN:	EXP				
PRIVATE HEALTH INSURANCE	Name of Company:	Member No:				
NEXT OF KIN	Name:..... Phone:..... Relationship to you:.....	**EMERGENCY CONTACT Different to Next Of Kin please**	Name:..... Phone:..... Relationship to you:.....			
YOUR EMAIL						
***To tailor appropriate care, encourage understanding and appreciation between people and cultures – do you identify as someone from a culturally and/or linguistically diverse background?**	☐ No ☐ Yes, please specify _____ Do you require an interpreter service? ☐ Yes ☐ No If yes, what language.....					
Are you (is the patient) of Aboriginal or Torres Strait Islander origin?	☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ None					
SMOKING HISTORY	☐ Non-smoker					
	☐ Ex-smoker	Year stopped	☐ Light	☐ Moderate	☐ Heavy	
	☐ Current smoker	Per day	Year started			
CURRENT ALCOHOL INTAKE	☐ Non-drinker					
	☐ Drinker	Days per week	Standard drinks per day			
ALLERGIES *Are you sensitive to anything? Food, medications, dressings etc...	☐ No ☐ Yes, please list allergy and reaction					
ANY SIGNIFICANT PAST MEDICAL HISTORY?						
ANY SIGNIFICANT FAMILY HISTORY?						

********** PLEASE TURN OVER TO COMPLETE DECLARATION **********

KILSYTH MEDICAL CENTRE

Do you authorise the practice to send you SMS appointment confirmations? YES / NO

Our practice 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 reminders sent to you?

□ Yes – via mail ***OR*** **□ Yes – SMS to this ph no: _____ □ No**

Your Health Information

To enable ongoing care and total quality improvement within this practice and in keeping with the Privacy Act (1988) and the Australian Privacy Principles , we wish to provide you with sufficient information on how your personal health information may be used or disclosed and record your consent or restrictions to this consent.

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 personal health information is used or disclosed.

The information we collected may be collected by a number of different methods and examples may include: medical test results, notes form consultations, Medicare and health insurance 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/guardian) are consenting, that on obtaining your personal health information it may be used or disclosed by the practice for the following purposes:

- follow up reminder/recall notices for treatment and preventive healthcare;
- for accounting procedures and the collection of professional fees;
- the diagnosis and treatment of any health condition, including the communication of relevant information only, to practice staff, specialists and other healthcare providers to ensure quality care is provided;
- Accreditation and Quality Assurance activities are conducted by professionally trained non-treating GPs and other professionally trained and qualified persons, e.g. General Practice Managers;
- For legal related disclosures as required by Court of Law;
- For the purposes of research where de-identified information is used;
- To allow medical students and staff to participate in medical training/teaching using only de-identified information;
- For disease notification as required by law;
- 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.

I, _____, give my permission for my personal health information to be collected, used and disclosed above. I understand only my relevant personal health information will be provided to allow the above actions to be undertaken and I am free to withdraw, alter to restrict my consent at any time by notifying this practice in writing.

Patient (please print): _____

Signature: _____ Date: _____

If not the Patient signing – Your name (please print): _____