

# 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:

Contact Information			
Gender:		Transgender:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Title:		Occupation:	
Surname:			
First Name:			
Date of Birth:		Country of Birth:	
Street Address:			
Postal Address: <i>(if different to above)</i>			
Home Phone:		Work Phone:	
Mobile Phone:		Email:	
Emergency Contact/Next of Kin Details			
Name:	Relationship to you:		
Address:			
Home Phone:		Mobile Phone:	
Healthcare Identifiers			
Medicare Number: _____	Ref: _____	Expiry: ____/____/____	
Dept. of Veterans' Affairs File Number: _____	<input type="checkbox"/> Gold <input type="checkbox"/> White		
Concession Pension/Health Care Card Number (Please circle): _____		Expiry: ____/____/____	
Cultural Identity			
To assist with health initiatives - are you Aboriginal and/or Torres Strait Islander?			
<input type="checkbox"/> No <input type="checkbox"/> Yes – Aboriginal <input type="checkbox"/> Yes - Torres Strait Islander <input type="checkbox"/> Yes - Aboriginal and Torres Strait Islander			
Do you identify as someone from a culturally and/or linguistic diverse background?			
<input type="checkbox"/> No <input type="checkbox"/> Yes - Please elaborate: _____ Do you require an interpreter service? <input type="checkbox"/> No <input type="checkbox"/> Yes			
Do you consent for your GP or Nurse to upload your medical information to My Health Record? <input type="checkbox"/> Yes <input type="checkbox"/> No			
ALLERGY INFORMATION - Do you have any allergies or are you sensitive to drugs or dressings?			
<input type="checkbox"/> No <input type="checkbox"/> Yes: _____ If yes, what type of reaction? _____			
LIFESTYLE RISK FACTOR INFORMATION			
<b>Smoking</b> <input type="checkbox"/> Non-smoker <input type="checkbox"/> Ex-smoker - Ceased date _____ <input type="checkbox"/> Smoker - Year commenced: _____ How many: ____ day / ____ wk			
<b>Alcohol</b> <input type="checkbox"/> Non-drinker <input type="checkbox"/> Drinker ____ day / ____ week / ____ month How many standard drinks on a typical day? _____			
How often do you have 6+ drinks on one occasion? <input type="checkbox"/> Never <input type="checkbox"/> < Monthly <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Daily or almost daily			
<b>Have any members of your family had:</b> (please tick boxes that apply only) <span style="float: right;"><b>If NO to all, please tick here <input type="checkbox"/></b></span>			
<input type="checkbox"/> <b>Heart Disease</b> <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Grandmother (Mothers side) <input type="checkbox"/> Grandfather ( Mothers side)			
<input type="checkbox"/> Grandmother (Fathers side) <input type="checkbox"/> Grandfather (Fathers side) <input type="checkbox"/> <b>No family history of Heart Disease</b>			
<input type="checkbox"/> <b>Diabetes</b> <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Grandmother (Mothers side) <input type="checkbox"/> Grandfather ( Mothers side)			
<input type="checkbox"/> Grandmother (Fathers side) <input type="checkbox"/> Grandfather (Fathers side) <input type="checkbox"/> <b>No family history of Diabetes</b>			
<input type="checkbox"/> <b>Breast Cancer</b> Which family member?: _____ <input type="checkbox"/> <b>Bowel Cancer</b> Which family member?: _____			
<input type="checkbox"/> <b>Other Relevant Family History:</b>			

**Information about fees:** Your Health Griffith is a private-billing practice. Children under 5 years, DVA card holders and all Aboriginal and Torres Strait Islander people are bulk billed. The fee for all other patients is \$85.00. Concession Card holders will receive a discounted fee. Longer appointments and procedures attract different fees and your doctor or reception staff will inform you of any costs. Full payment is expected at the time of consultation. If there are any difficulties regarding this, please inform us prior to your appointment.

**WorkCover** consultations require a claim number. Please inform reception if you are seeing the doctor for a work injury. Full payment is required on the day for WorkCover claims that do not currently have a claim number. **Missed Appointments:** Patients who fail to attend a scheduled appointment will be charged a non-attendance fee of up to \$50 (depending on the appointment length) to be paid before the next consultation.

**\*COMPLETE OVER PAGE\***

## **Patient Consent** - Please read this consent form carefully prior to signing.

This general 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. 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 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/quality assurance activities to improve individual, 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, (please print name) \_\_\_\_\_ 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. I also agree to Your Health Griffith's Billing and Non-attendance Policy.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If not patient signing - your name (please print) \_\_\_\_\_

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

Are there any custody/guardianship arrangements in place for the patient that we should be aware of?  Yes  No

### **PRACTICE USE ONLY:**

Witnessed by: (staff signature) \_\_\_\_\_