Vital Signs
Medical Centre

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 the new patient record form as below:

Contact Information:	
Gender:	Please Circle - **Woman Man Self Described (please specify):**
Title:	
Pronoun:	Please Circle - **She/Her He/Him They/Them Other (please specify):**
Surname:	
First Name:	
Date of Birth:	
Street Address:	
Home Phone:	
Work Phone:	
Mobile Phone:	
Email:	
Occupation:	
Emergency Contact Details:	
Name:	**Relationship to you:**
Home Phone:	
Mobile Phone:	
Next of Kin:	
Name:	**Relationship to you:**
Home Phone:	
Mobile Phone:	
Healthcare Identifiers:	
Medicare Number:	**Ref:** **Expiry: ___/_____**
Concession Card Number:	**Expiry: ___/_____**
☐ **Pension Card** ☐ **Health Care Card** ☐ **Seniors Commonwealth Card**	

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Dept. of Veterans' Affairs File Number: ☐ **Gold** ☐ **White**

Overseas Students, Visitors or Non Medicare Card Holders:

Insurance Company: **Policy Number:** **Expiry: ___/_____**

Cultural Identity:

To assist with health initiatives - are you Aboriginal and/or Torres Strait Islander?

☐ No ☐ Yes – Aboriginal ☐ Yes - Torres Strait Islander ☐ Yes - Aboriginal and Torres Strait Islander

Country of Birth: _____

As Australia is a genuinely multicultural society, and to tailor appropriate care, encourage understanding and appreciation between people from different nationalities and cultures - do you identify as someone from a culturally and/or linguistic diverse background?

☐ No ☐ Yes - Please give detail _____

If yes, do you require an interpreter service? ☐ No ☐ Yes

Your Health Information:

ALLERGY INFORMATION - Do you have any allergies or are you sensitive to drugs or dressings?

☐ No ☐ Yes – provide details:

CURRENT MEDICATIONS – Please list all your current medications, including complementary and over-the-counter medicines (e.g. homeopathic medicines such as vitamins and minerals etc.)

MEDICAL HISTORY - Do you have or have you had a history of the following?

☐ Surgery – provide details:

☐ Asthma

☐ Diabetes

☐ Hypertension

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☐ Chronic Illness

☐ Other – provide details

LIFESTYLE RISK FACTOR INFORMATION -

Smoking

☐ No

☐ Ceased - date_____

☐ Yes - how many ___ day / ___ week

Alcohol

☐ No

☐ Yes - how many ___ day / ___ week / ___ month

Recreational Drug Use

☐ No

☐ Yes - type_____ frequency _____

Family Health History Information:

Have any members of your family have:

☐ Heart Disease

☐ Asthma

☐ Diabetes

☐ Hypertension (high blood pressure)

☐ Mental Illness

☐ Cancer – type:

☐ Other significant - provide details:

My Health Record Consent:

Our practice actively uses and shares information with My Health Record. This allows our doctors and nurses to provide you with the best possible care and outcomes. Do you consent to us viewing or uploading information to your My Health Record?

☐ Yes ☐ No

Consent to Contact:

Our practice uses an active recall and reminder system. We may contact you via phone to confirm your appointments, we may also contact you regarding results, immunisations, annual skin checks, pap smears etc.

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Do you consent to phone contact? ☐ Yes ☐ No

Practice Policy and Patient Consent :

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. Please read over the privacy policy located in the reception area, or to obtain a copy ask a receptionist.

Our Practice has a policy for "Failure to attend". A patient is considered to be a "Failure to Attend' when they have missed their appointment and have not notified reception staff at least 2 hours prior that they will not be able to attend their appointment. Patients who do not attend their appointment may be subjected to a fee.

By signing below you declare all information you have provided on this form to be true and correct and consent to the Practice's Privacy Policy on collection of personal information.

If you are under 16 years old this is to be signed by a parent or guardian.

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)_____

Witness Name: _____

Date: _____