**NEW PATIENT INFORMATION FORM**

*Payment for your consultation must be made directly after your consultation,*

|  |
| --- |
| **New Patient Information** |
| **Date of Birth**  |  | **Title:** Miss, Mrs, Ms, Mr, Mstr, Dr  |
| **Surname** |  | **First Name** |  |
| **Middle Name** |  | **Preferred Name** |  |
| **Birth Sex** |  Male Female | **Gender Identity** |  Male Female non-binary Transgender MTF/FTM Other: |
| **Ethnicity**  |  Australian, non-indigenous Aboriginal Torres Strait Islander Aboriginal & Torres Strait Islander Other nationality: |
| **Australian****Residential Address** |  |
| **Suburb:** |  | **Post Code:** |  |
| **Postal Address**(If different to above) |  |
| **Suburb:** |  | **Post Code:** |  |
| **Contact Phone** | **Mobile:** | **Work:** | **Home:** |
| **Email Address** |  |
| **Medicare Number** |  | **Ref No:** |  | **Expiry:** |  |
| **Concession Card** |  Pension Health Care Card Seniors Health Care Card  | **Card No:** | **Expiry:** |  |
| **DVA**  |  Gold White | **Card No:** | **Expiry:** |  |
| **Occupation** |  |

|  |  |
| --- | --- |
| **Emergency Contact Person**  Same as Next of Kin | **Next of Kin** |
| **Name** |  | **Name** |  |
| **Relationship** |  | **Relationship** |  |
| **Phone No** |  | **Phone No** |  |

|  |
| --- |
| **Parent / Guardian details of children 16 years and under** |
| **First Name** |  | **Surname** |  |
| **Date of Birth** |  | **Medicare No:** |  | **Ref:** |  |

**I CONSENT TO THE FOLLOWING (Please tick accordingly):**

I agree to my emergency contact and/or next of kin being contacted in the case of an emergency or if we are unable to contact you for healthcare reasons.

 I agree to receive SMS messages and/or emails for appointment confirmations, results follow up notifications and preventative health reminders.

 I understand that the doctors at this practice will not prescribe Schedule 8 drugs, antipsychotics, benzodiazepines, or opioids to New Patients

 I agree to the GP and/or Nurse at Birtinya Medical Centre accessing and uploading information to My Health Record for the provision of healthcare in accordance with national legislation.

 I Understand Birtinya Medical Centre is a private billing practice and payment must be made directly after the consultation

**Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**BIRTINYA MEDICAL CENTRE**

Privacy and Consent

To enable ongoing care and total quality improvement within this practice, and in keeping with the NPP (National Privacy Policy) 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 collect may be collected by a number of different methods and examples may include: medical test results, notes from 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 GP’s and other professionally trained and qualified persons eg. General Practice Managers.
* 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.
* 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 as described 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 or restrict my consent at any time by notifying this practice in writing.

Patient Name: (Please Print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

If not Patient signing -Your name (Please Print)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Recognizing & Rewarding **Quality in Practice**

Disclaimer: Whilst every effort is made to ensure accuracy, Quality in Practice Pty Ltd does not accept any liability for any injury, loss or damage incurred by use of, or reliance on the information included within this sheet.

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**BIRTINYA MEDICAL CENTRE**
General Health Questionnaire

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_D.O.B:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you suffer or have you suffered from and of the following: *please tick*

* Cancer
* Spinal pain or injury
* High blood pressure
* Depression
* Anxiety or other mental illness
* Asthma/ other chronic lung diseases
* Epilepsy
* Any surgical operations
* Angina, Heart Attack, Bypass Surgery,
Other heart diseases
* Any Major Accidents
* Diabetes
* Abdominal complaints
* Liver diseases
* Kidney diseases
* Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you allergic to or have you had any significant side effects from any medication
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there a history in your family of any of the above listed illnesses, please record them here
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Current medications & supplements i.e. vitamins etc.
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Weight\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Height\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Waist measurement\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke or have you ever smoked?
*Please circle*  YES / NO How many per day\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Year commenced\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year Ceased\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Do you drink alcohol?
*please circle* YES / NO How many standard drinks per day\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
How many days per week do you drink?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
How many days per week do you exercise?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
What type of exercise do you do?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_