Together MEDICAL
family practice

NEW PATIENT FORM – 2 pages

office use only:		
Medicare card:	Yes	No
Concession Card:	Yes	No

Personal details:

Mr/Mrs/Ms/Miss/Mast/Dr

Surname: _____First Name: _____

Date of Birth: _____

Address: _____Postcode: _____

Suburb: _____Day Time Phone: _____ Mobile: _____

Email address: _____

Emergency Contact Person: _____

Relationship to you: _____ Contact phone number (mobile): _____

Your cultural identity:

Aboriginal □ Torres Strait Islander □ Non-Indigenous □ Other _____

Fee structure / Payment information:

Concession card type (circle one): Pension / DVA / Health Care / child under 16 / No concession card, private fees apply

Medicare Number _____ Ref No. Next to name: _____

Expiry: ____/_____/_____

Concession Card Number _____

Expiry: ____/_____/_____

DVA Card Number _____ DVA Gold Card / White Card (circle one)

Expiry: ____/_____/_____

Do you wish to receive SMS appointment reminder messages? Yes or No

FEEDBACK: How did you find out about our Medical Centre (please specify) _____

Please speak to reception if you would like to transfer your medical history to this clinic.

PLEASE TURN OVER AND COMPLETE HEALTH SUMMARY & CONSENT SECTION ON PAGE 2

Do you have any allergies, or adverse effects to any medications? YES / NO

If yes, please list:

_____

_____

Do you have any on-going health problems? YES / NO

If yes, please list:

_____

_____

Please list all current medication you are taking; or circle None

_____

_____

Do you have a family history of any major medical conditions? (eg Diabetes, Heart Disease, Stroke, Asthma or Cancer)
Please specify condition, family member effected and age of diagnosis if known:

_____

_____

Do you smoke? Y or N.

If you are an ex-smoker, when did you stop? _____. If Yes, How many per day? _____

Do you consume alcohol? No / Yes. If Yes, how many standard drinks per day _____ Per week _____

Immunisations:

Childhood immunisations: Up to date? (circle one) Yes / No.

If No, list outstanding immunisations?: _____

Influenza Date _____ Pneumonia Date _____ Tetanus Date _____

Care Plans: Are there any current care plans in place from your previous GP? Yes / No
If yes, please list details: _____

Women's Health, when was your last Pap Smear? Date if known _____

Men's Health, if over age 45, when was your last Prostate check? Date if known _____

Heart check and cholesterol review? _____

I acknowledge that I have read and understand the Consent section attached to the New Patient Form (see back of clipboard) Signed _____ Date _____

Consent:

We Care for your Health.

We require your consent to collect personal information about you. Please read this information carefully, and sign where indicated. Together Medical Family Practice collects this information for the primary purpose of providing quality health care. We may require your full medical history so that we can properly assess, diagnose, treat and be proactive in your health care needs. We will use the information you provide in the following ways: Administrative purposes. Billing purposes, including compliance with Medicare Australia requirements. Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice. This may occur through referrals, or for medical tests and in the reports/results returned to us following the referrals. To contact you or your family for the purposes of Recalls & Reminders. Patient information shall not be released to a third party without the express consent of the patient. At times, there may be a fee for your treatment. The fees will be discussed with you prior to treatment.

I have read the information above and understand the reasons why my information is collected. I understand that I am not obliged to provide any information requested of me, but that my failure to do so may compromise the quality of the health care and treatment given to me. I am aware of my right to access the information collected about me, except in circumstances where access might legitimately be withheld. I understand 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 this practice for the purposes set out above.

I understand that the practice email is only for admin purposes and no medical advice is provided by email. All medical issues including results must be discussed with my GP during consultation.

<u>Cancellation policy</u>

We respect that your time is valuable and we appreciate that you understand ours is too. We therefore require at least 12 hours notice if you wish to cancel your appointment so that we can give your appointment time to another patient.

<u>Failure to Attend</u>

Where a patient fails to attend their appointment on more than one occasion without notifying the clinic of their cancellation, you will be charged a missed appointment fee equivalent to the length of your booking. This fee will need to be settled prior to you seeing our doctor on your next visit.

<u>Online Bookings</u>

The Failure to Attend and Cancellation policies set out above apply to bookings made online also. In addition to this, where a patient fails to attend their appointment on more that one occasion, you will be prevented from booking any further appointments online and must make all further bookings in person or by telephone.