NEW PATIENT INFORMATION

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***** WE BULK BILL PATIENTS UNDER 12! *****

Please complete your personal details below

Title: Mr, Mrs, Ms, Miss, Master (Please Circle) **Date of Birth:......................**

Surname:... **Preferred Name:.................**

Given Names:...................................... **Male/ Female (Please Circle)**

Country of Birth:....................... **Aboriginal/TSI/None (Please Circle)**

Marital Status: Married, Single, Defacto, Divorced, Widowed (Please Circle)

Home Address:................................... **Suburb:............................**

State:... **Post Code:.........................**

Contact Numbers:

Home:........................ **Mobile:.................** **Work:......................**

Occupation:............................. **Email:..**

Do you require a translator? Yes/ No (please Circle)

Medicare No:.................................... Ref No: .... Expiry Date: ....
(10 DIGIT NUMBER)

Pension/Concession Card No:........................... Expiry Date:..................

NEXT OF KIN
Please List the name and phone number of someone to contact in case of an emergency and their relationship to you

Name:.................................. **Relationship:..**

Phone:................................ **Address:...**

How did you hear about us? Friends/Family Yellow Pages Newspaper

Alex Hills Shopping Ctr Letter in Letterbox Other.................................. (please circle)

ONE LIFE MEDICAL

HEALTH INFORMATION COLLECTION AND USE CONSENT FORM

As a patient of our medical practice we require you to provide us with your personal details and a full medical history, so that we may properly assess, diagnose, treat and be proactive in your health care needs.

We aim to protect the privacy and secure storage of your health information. You can request a copy of our privacy policy, which includes information about the collection, use and disclosure of your health information.

We require your consent to collect personal information about you and to use the information you provide in the following ways. Please read this consent form carefully, and sign where indicated below.

- Administrative purposes in running our medical practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your healthcare including treating doctors and specialists outside this medical practice. This may occur though referral to other doctors, or for medical tests and in the reports or results returned to us following referrals.
- Disclosure to other doctors in the practice, locums etc. attached to the practice for the purpose of patient care and teaching.
- To comply with any legislative or regulatory requirements e.g. notifiable diseases.
- For reminder letters which may be sent to you regarding your health care and management.

You can decline to have your health information used in all or some of the ways outlined above but it may influence our ability to manage your health care to provide the best outcome for you.

ONE LIFE MEDICAL

HEALTH INFORMATION COLLECTION AND USE CONSENT FORM

I have read the information above and understand the reasons why my information must be collected. Y/N

I understand that I am not obliged to provide any information requested of me, but failure to do so may compromise the quality of health care and treatment given to me. Y/N

I am aware of my rights to access the information collected about me, except in some circumstances where access may be legitimately withheld. I will be given an explanation in these circumstances. Y/N

OR

I am unsure and would like to discuss this further with someone from the medical practice before I sign. Y/N

Patient's Name:……………………………………… Date: ……………………….

Patient's Signature: …………………………………

Signed as Guardian for Child: ……………………..

Name: (Printed) ……………………………………..

MEDICAL HISTORY

PLEASE TAKE THIS FORM WITH YOU WHEN YOU SEE THE DOCTOR

NAME: ……………………………………………………………

Family Medical History (eg Diabetes, Heart Condition etc):

Mother:

………………………………………
………………………………………
………………………………………

Father:

……………………………………………
……………………………………………
……………………………………………

Other relatives:

……………………………………………………………………………………………………

Social History (eg Live alone/with Partner etc): …………………………………
……………………………………………………………………………………………………

SMOKER (Please tick)	How many per day?	Year commenced?	Year ceased
No ( )			
Yes ( )			
Ex-Smoker ( )			

How many days per week do you usually consume alcohol? (Please Circle)

Never (Non-Drinker) **Less than monthly** **1-2 days per month**

1-2 days per week **3-4 days per week** **5-6 days per week**

Every day

On a day drinking alcohol, how many standard drinks would you consume? …………………………………

Allergies: Yes/No (Please Specify)

Food/Animal/Insect

…………………………………………
…………………………………………
…………………………………………

Medication

……………………………………………
……………………………………………
……………………………………………