Glengarry Medical Group
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 is kept up to date and accurate.

Please assist us by completing the following:

Title (please circle)	Mr Mrs Ms Miss Other:		
Surname			
First Name		Middle Name	
Marital Status			
Country of Birth			
Ethnicity			
Date of Birth			
Street Address			
Suburb		Post Code	
Home Phone			
Work Phone			
Mobile Phone			
Email			
Your Occupation			
Medicare Number	Please hand your card to reception Ref No:	Expiry Date	
DVA Gold / White (Please circle)	Please hand your card to reception	Expiry Date	
Pension Number	Please hand your card to reception	Expiry Date	
Healthcare Card Number	Please hand your card to reception	Expiry Date	
Private Health Fund	Yes or No & name of Fund:		
Next of Kin (Name & Contact No)			
Relationship to Next of Kin			
Emergency Contact (Name & Contact No)			
Relationship to Emergency Contact			

Please note that we are a private billing practice and payment of your account is required on the day of your consultation.

Reminder Systems:

Our practice provides our patients with preventative care and early case detection reminders eg immunisations, annual health checks and assessments, skin checks, cervical smears etc.

These will either be sent in the form of a letter, phone call or sms.

When we need to contact you what is your preferred method of contact:

☐ Home phone ☐ Mobile phone ☐ Mail

Australia is a genuinely multicultural society. To tailor appropriate care, encourage understanding and appreciation between people different nationalities and backgrounds – do you wish to identify as someone from a culturally and/or linguistic diverse background? □ No □ Yes

To assist with health initiatives, do you identify as Aboriginal or Torres Strait Islander?
□ No □ Yes – Aboriginal □ Yes – Torres Strait Islander □ Yes – Both

Your health history – do you have or have you had a history of?

□ Operations – details and when?

……
……

□Asthma □Hypertension

□Chronic illness / lung problems □Other

Do you have any allergies (including food) or are you sensitive to drugs or dressings:

□Yes (if yes please list below) □No
……..
……..

What type of allergic reaction is caused: ……..

Immunisations – have you had the following immunisations?

Tetanus booster	date	□don't know	□haven't had one
Hepatitis B	date	□don't know	□haven't had one
Hepatitis A	date	□don't know	□haven't had one
Influenza	date	□don't know	□haven't had one
Whooping Cough	date	□don't know	□haven't had one
Pneumococcal	date	□don't know	□haven't had one
Polio	date	□don't know	□haven't had one

Children's immunisations – if completing form for a child, are their immunisations up-to-date?
□Yes □No

Current medications and dosage (including over the counter medications, vitamins and minerals):
……
……
……

Family history:
Have any members of your family (inc siblings or children) had/have:
Please list whether maternal or paternal side of family.

□ Diabetes – if yes who ……

□ Asthma – if yes who ……

□ Heart Disease – if yes who …….. ……..

□ Mental illness – if yes who ……..

□ Cancer – if yes who, where and type ……

□ Lung problems – if yes who ……

Mother - Living □ or Deceased □ - age at death & cause …….
Father - Living □ or Deceased □ - age at death & cause ……..
Siblings (how many) …….
- Living □ or Deceased □ - age at death & cause ……..
Any siblings with medical problems ……..
Any children with medical problems ……

Social history:

Activities: (ie Walking,Cycling etc).....

□ tobacco: ……..per day/ week or ceased smoking – date ……..
□ alcohol: ……..per day/ week / month (circle the one applicable)
□ drug use: (type and frequency) ……

Height: ……..cms Weight ……kgs

Blood pressure: when was the last time your blood pressure was taken? ……..

For those 65 years and older: when was the last time you were immunised?

Influenza	Date ……	□ not sure	□ never
Pneumococcal	Date …….....	□ not sure	□ never

Females: when did you last have?

Cervical smear	Date ……	□ not sure	□ never

Breast check/Mammogram Date …… □ not sure □ never

Males: when did you last have an overall check-up – including prostate screen?

Date …… □ not sure □ never

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Welcome to Glengarry Medical Group

To enable ongoing care and total quality improvement within this practice, and in keeping with the Privacy Act 1988 and National Privacy Principles, 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 (eg 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 preventative 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-treatment 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.
- Participation in My Health Record (only on specific consent of the patient or guardian)

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.

In the interests of safety, CCTV is in operation in some public areas.

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) _____

Signature: _____Date:_____

OR

My signature below indicates that I consent to the handling of information by this practice for the purposes set out above on behalf of my child:

Name of Child: _____ DOB: _____