New Patient Information Form - Strictly Confidential

At ALL times we are required to ensure your details are treated with the utmost confidentiality.

Contact Information	**Last Name:**	**First Names:**
Gender:	**Title: Mr, Mrs, Ms**	**DOB:**
Street Address:		
Postal Address:	*(if different to above)*	
Phone Nos:	Home: Work: Mob:	
Email:		
Emergency Contact	Name:	Relationship to you:
Home Phone:		Mobile Phone:
Next of Kin	Name:	Relationship to you:
Home Phone:		
Healthcare Identifiers	Medicare Number:	Ref No.: Expiry: ___/___
Dept. of Veterans' Affairs File Number:		☐ Gold ☐ White
Concession (Pension/Health Care) Card 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

Do you identify as someone from a culturally and/or language diverse background? - ☐ No

☐ Yes Please elaborate _____

Do you require an interpreter service? ☐ No ☐ Yes

ALLERGY INFORMATION

Do you have any allergies or are you sensitive to drugs or dressings? ☐ No **or** ☐ Yes

Provide Details – Allergic to: _____

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.)

Your Medical History: had any of the following? Tick	**Lifestyle Risk Factor Information**
☐ Surgery – provide details:	***Smoking*** ☐ No ☐ Ceased - date_____ or N/A ☐
	☐ Yes - how many ___ day / ___ week
☐ Asthma ☐ Diabetes ☐ Chronic Illness	***Alcohol*** ☐ No ☐ Yes
☐ Hypertension / Heart Disease	- how many ___ day / ___ week / ___ /mth
☐ Mental Health Issues	***Recreational Drug Use***
☐ Other – provide details:	☐ No ☐ Yes - type_____ frequency ____
Family Health History Information	
Have any members of your family have:	☐ Mental Illness
☐ Heart Disease ☐ Diabetes ☐ Asthma	☐ Cancer – type:
☐ Other significant - provide details:	

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Patient Consent - *We need to record your consent, or restrictions to this consent.*

► **Amity Family Practice collects information from you for the purpose of providing you with quality health care.** *In keeping with the Privacy Act 1988 and Australian Privacy Principles, we will provide you with information on how your personal information may be used or disclosed.*

► **Personal information will only be used for the purposes for which it was collected or as permitted by law, and we respect your right to determine how your information is used or disclosed.**

Types of information may include: medical test results, notes from consultations, Medicare 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, parent or guardian) **are consenting to the collection of your personal information, that it may be used or disclosed by the practice for the following purposes:**

- *Administrative purposes:* billing purposes, including compliance with Medicare requirements.
- *Follow-up reminder/recall notices*: for treatment & preventative healthcare, often issued by SMS.
- *Disclosure to others involved in your health care:* That is when treated *by other doctors* in this practice, or by treating doctors, allied health professionals and specialists outside this medical practice via referral, or for medical tests, and in the reports or results returned to us following the referrals.
- *Accreditation and Quality Assurance Activities within the Practice:* to improve health care.
- *For Legal Disclosure as may be Required by a Court of Law.*
- *To comply with any legislative or regulatory requirements*: eg Reporting communicable diseases.
- *For the purposes of research only where de-identified information is used.*
- *For medical students/staff to participate in training/teaching*: using only de-identified information.
- *Uploading to MY Health Records: unless you have already opted out or written request not to upload.*

I, _____ have read the information above and understand the reasons why my information must be collected, and the purposes for which my information may be used or disclosed. I understand that if my information is to be used for any purpose other than that set out above, my further consent will be obtained.

I, _____ also give permission for my personal information to be collected, used and disclosed as described above, including contact via SMS to my mobile phone number.

I understand only my relevant personal 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) _____

Please sign below. For electronic signatures , click check box to agree ☐

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)