Newcastle General Practice – New Patient Form

Patient Registration and Information Form

Family Name: _____ Given Name: _____ Middle Name: _____

Preferred Name: _____ Date of Birth: _____ Title: Mr/Mrs/Ms/Miss/Dr/Other _____

Address:

_____
_____ Postcode: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Email:

_____
_____

ETHNICITY:

Aboriginal/Torres Strait Islander/Australian (Non Indigenous)/Other: _____ Country of Birth: _____

Medicare Number:

Line No.

Expiry Date:

Pension / Concession Health Card:

Expiry Date:

DVA:

Gold:

White:

Card No:

Expiry Date:

NEXT OF KIN: Family Name: _____ Given Name: _____ Relationship: _____

Address: _____ Contact Phone No: _____

EMERGENCY CONTACT: Family Name: _____ Given Name: _____ Relationship: _____

Address: _____ Contact Phone No: _____

WORKERS COMPENSATION

Is your appointment today related to a WorkCover or CTP Claim Yes / No Claim No: _____

Has your claim been approved: Yes / No Case Manager Name: _____

Insurer: _____ Phone: _____ Fax: _____

Email: _____ Address: _____

CONSENT FOR REMINDER SYSTEM AND NON-URGENT APPOINTMENT via SMS

Our practice uses a reminder system to improve the quality of your health care. The practice sends reminders by SMS for procedures such as vaccinations, cervical screening, care plans and other health reviews.

We also use this system to send appointment reminders and you will receive messages when your doctor wants to see you for a non-urgent appointment.

QUALITY IMPORVEMENT

Our practice undertakes research, professional development, and quality improvement assurance/improvement activities to improve patientcare. All people accessing personal health information for this purpose have signed a written confidentiality agreement.

HOW DID YOU HEAR ABOUT US?

Friend / Word of Mouth / Other Doctor / Google / Yellow Pages / Hot Doc / Other: _____

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 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 other involved in your health care including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to use following referrals.

• Disclosure to other doctors in the practice, locums, etc. attached to the practice for the purpose of patient care and teaching.

• For research and quality assurance activities to improve individual and community healthcare and practice management. Usually information that does not identify you is used but should information that will identify you be required you will be informed and given the opportunity to 'opt out' of any involvement.

• To comply with any legislative or regulatory requirement e.g. notifiable diseases.

• For reminder letters which may be sent to you regarding your healthcare 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.

☐ I have read the information above and understand the reasons why my information must be collected.

☐ I understand that I am not obliged to provide any information requested of me, but failure to do so my compromise the quality of healthcare and treatment given to me.

☐ 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.

☐ I understand that if my information is to be used for any other purpose other purpose other than set out above, my further consent will be obtained.

☐ I consent to the handling of my information by the practice for the purpose set out above, subject to any limitations on access or disclosure of which I notify this practice.

☐ I have read and understand all information provided above regarding fees, reminders, privacy and freedom on information. I am aware that at the conclusion of all consultations there will be a request for full payment of the account. I am also aware that should a debt collection agency be employed to recover any unpaid accounts in relation to consultations that additional collection fees will apply.

☐ I consent to my health record being reviewed as a part of the quality improvement activities at this practice.

☐ I consent to being contacted with reminders as a part of the quality improvement activities at this practice.

OR

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

Name of Patient/Guardian signing form: _____ Signature: _____ Date: ____/____/____

CLINICAL INFORMATION

REGULAR DOCTOR

Do you have a regular? Yes/No Doctor Name: _____
Phone: _____

Doctor Surgery Details:

_____
_____

HEALTH CONDITIONS/HISTORY

Please circle if you have ever suffered from any of the following conditions:

Yes/No **Heart Attack** Yes/No **Thyroid Problems** Yes/No **Angina or Coronary Heart Disease**

Yes/No **Asthma** Yes/No **Osteoporosis** Yes/No **Deep Vein Thrombosis (DVT) or Pulmonary Embolus (PE)**

Yes/No **Dementia** Yes/No **Heart Failure** Yes/No **COPD or chronic bronchitis or emphysema**

Yes/No **Glaucoma** Yes/No **Diabetes** Yes/No **Irregular Heart Beat or Atrial Fibrillation (AF)**

Yes/No **Epilepsy (TIA)** Yes/No **High Blood Pressure** Yes/No **Stroke or Transient Ischaemic Attack**

Yes/No **Cancer** Yes/No **Hepatitis** Yes/No **Peripheral Vascular Disease (PVD or PAD)**

Yes/No **Kidney Problems** Yes/No **Mental Health Problems e.g. Depression**

Please list any other serious illnesses OR operations and the date they started:

_____ _____
_____ _____

_____ _____
_____ _____

Please list all Medications you are currently taking. Include inhalers, injections, tablets, creams & eye drops Medication:

Medication: _____ Dose: _____ Medication: _____ Dose: _____

Medication: _____ Dose: _____ Medication: _____ Dose: _____

Medication: _____ Dose: _____ Medication: _____ Dose: _____

SCREENING – Women

When was your last cervical screening done? _____ What was your result? _____

Yes/No Are you pregnant now? If yes baby due date: _____

Private / Public Birth? Hospital / Doctor details: _____

Yes/No Have you ever had a pap smear? Date of most recent Pap Smear: _____

Yes/No Have you had a mammogram? Date of most recent Mammogram: _____

SCREENING

Yes/No If 50 or over have you participated in bowel screening program?

If yes when was your last bowel screen done? _____

Yes/No Have you ever had a colonoscopy?

Have you ever had a result from bowel screening or colonoscopy that was positive or that required further treatment? Please give details if yes: _____ _____

FAMILY HISTORY

Yes/No Is your mother alive? If no age at death: _____ Cause of death: _____

Yes/No Is your father alive? If no age at death: _____ Cause of death: _____

Significant Family History

Mother ☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke

☐ Colon Cancer ☐ Depression ☐ Breast Cancer Other: _____

Father ☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke

☐ Colon Cancer ☐ Depression ☐ Breast Cancer Other: _____

SOCIAL

Marital Status: Single / Married / Defacto / Separated / Divorced / Widowed

Sexuality: Heterosexual / Homosexual / Bisexual

Yes/No **Advance Care Directive** Yes/No **Enduring Guardian**

Accommodation: Own Home / Relative Home / Other Private House / Hostel / Nursing Home / Homeless / Rental Home

Lives with: Spouse / Partner / Relative / Alone

Has Carer: Yes/ No / Self Carer Details: First Name: _____ Surname: _____

Address: _____ Suburb: _____ Postcode: _____

Phone: _____ Alternate Contact Number: _____
Relationship: _____

Yes/No **Do you feel safe in your home?**

OCCUPATION

Current occupation: _____ Previous occupations: _____

ADF Service: Never Served / Current ADF – Permanent / Current ADF – Reserves / Past ADF Reserves or Permanent

ALCOHOL

Current alcohol intake: Days per week: 1/2/3/4/5/6/7 Standard drinks per day: _____

Past alcohol intake: Nil / Occasional / Moderate / Heavy Year Started: _____ Year Stopped: _____

TOBACCO

Current smoking history : Non-smoker / Ex-smoker / Smoker Type: Cigarettes / Cigars / Pipe Packets per week: _____ Year Started: _____ Yes/No Would you like advice to stop?

ALLERGIES

Are you allergic to anything that you know of e.g. medicines, metals, Elastoplast, latex?

_____ _____
_____ _____

_____ _____
_____ _____