Hampstead HEALTH Family Practice

NEW PATIENT FORM

Mr/Master/Mrs/Ms/Miss (please circle) other _____ Date of birth_____

First name _____ Surname _____

Home address _____ Suburb _____

Home ph _____ Work ph _____ Mobile _____

Country of birth _____ Other cultural background _____

Aboriginal ☐ Torres Strait Islander ☐

Is English your first language? Yes / No If no please indicate language _____

Do you have private health insurance? Yes/No Name of fund _____

Next of kin

First Name: _____ Last name _____

Relationship _____ Phone _____

Emergency contact

I authorise the following person to take messages regarding a recall, reminder or change of appointment

First Name: _____ Last name _____

Relationship _____ Phone _____

Office use only

Medicare card _____ **Ref** _____ **Expiry date** _____

Pens/HCC _____ **Expiry date** _____

Received back by_____ **Entered & scanned By** _____ **Checked by** _____

Hampstead HEALTH Family Practice

Practice information collection statement

Hampstead Health Family Practice requires your consent to collect personal information about you.

Hampstead Health Family Practice collects information from you for the primary purpose of providing quality health care.

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 pro-active in your health care needs. This means we will use the information you provide in the following ways:

- Administrative purposes in running our medical practice;
- Billing purposes, including compliance with Medicare Australia;
- Disclosure to others involved in your health care, including treating doctors and specialists outside this practice. This may occur through referral to other doctors, or for medical tests and in the reports returned to us following the referrals
- Disclosure to other doctors including locums and to allied health workers and nurses who work in the practice
- Disclosure to visiting teachers and accreditation surveyors for the purposes of teaching and accreditation of the practice; and/or Disclosures for research and quality assurance activities
  to improve individual and community health care and practice management. This information will be de-identified.

I have read the information above and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling patient information. I understand that I am not obliged to provide any information requested of me, but that my failure to do so might 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 some 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. By completing the section below and providing a signature, I consent to the handling of my information by this practice for the purposes set out above, subject to any limitation on access of disclosure that I notify the practice of.

Patient name: _____

Patient signature: _____

Date: _____

Consent for practice communications

Please read this carefully before signing

As part of the provision of health care services to you we may send you the following types of communications via telephone, SMS or letter:

1. ***Appointment reminders*** *– notifications to you to remind you of upcoming appointment dates with the practice as well as allowing you to confirm your appointment.*

2. ***Clinical reminders*** *- notifications to you to remind you to contact the practice to arrange appointments for regular clinical check-ups, medical procedures, immunisations due*

3. ***Clinical communications*** *- communications to you about your clinical care at the practice such as returned pathology results or clinical messages from the medical practitioner*

4. ***Health awareness*** *– communications to you in relation to general health care information and health care services provided by this general practice including notification about changes to our clinic opening hours, and information about health care services provided by this general practice.*

   Please provide your email address here if you would like to receive health awareness from this practice via email:

   Email address: _____

Acknowledgements and Consent

I acknowledge and agree that, in the course of providing health care services to me, the general practice may need to use my personal information as set out in this form.

I acknowledge that the practice will use contact details provided by me (as updated by me from time to time) to communicate with me.

Please complete and sign below if you understand and agree to the acknowledgements and consent set out above.

Patient Name: _____ *DOB:* _____

Patient/Guardian name: _____
(if patient is under 16)

Signature: _____

Received and entered by ……..Checked and scanned by ……..……..……

PERSONAL HEALTH HISTORY

NAME: ……..…….. **D.O.B:** ……

MARITAL STATUS: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ De facto

OCCUPATION: ……

Do you have a regular GP elsewhere? If so please provide details below:

Dr's name: …….. **Surgery name and address:** ……

Do you have or have you had a history of the following? (please give dates and description)	
☐ **Operations**	
☐ **Asthma**	
☐ **Diabetes**	
☐ **Hypertension**	
☐ **Mental Illness**	
☐ **Chronic Illness**	
☐ **Other**	

Do you have any ALLERGIES, or are you sensitive to drugs or dressings?
☐ No ☐ Yes Allergy to: …….. Reaction type: …….

Do you use any of the following: (list amount where appropriate)	
Tobacco	☐ No ☐ Yes – How many cigarettes per day? … ☐ Ceased smoking **Date Ceased: ….**
Alcohol	☐ No ☐ Yes – How many days per week? … How many alcoholic drinks at a time? ……
Illicit Drugs	☐ No ☐ Yes – Type? ……. Frequency of use? ……

Female clients: When was your last Pap smear?

More than 2 years ago? ☐	More than 4 years ago?	**Result:** ☐ **Normal** ☐ **Abnormal**

Current medications including over the counter medications, vitamins and minerals:
Please list them here:

Have any members of your family had any of the following :	
Mother ☐ Still living ☐ Deceased	☐ Heart Disease ☐ Asthma ☐ Diabetes ☐ Mental Illness ☐ Cancer – Type: ……☐ Other: ……
Father ☐ Still living ☐ Deceased	☐ Heart Disease ☐ Asthma ☐ Diabetes ☐ Mental Illness ☐ Cancer – Type: ……☐ Other: ……
Brother/s	☐ Heart Disease ☐ Asthma ☐ Diabetes ☐ Mental Illness ☐ Cancer – Type: ……☐ Other: ……
Sister/s	☐ Heart Disease ☐ Asthma ☐ Diabetes ☐ Mental Illness ☐ Cancer – Type: ……☐ Other: ……

Doctor to complete the following

Height	cm	**BMI**	
Weight	kg	**BP (sitting)**	/ mmHg

Entered by ……..…… **Scanned by** ……..……..