NEW PATIENT INFORMATION SHEET

Rosslea Medical Centre Healthy Lifestyle

This medical information is important to provide you with the best quality care. This form complies with the RACGP *Standards for general practices*. This means your personal health information is kept private and secure, as required by federal and state privacy laws. If you have any concerns, please leave blank and discuss with your GP. Please notify us promptly of any changes in your contact details. Accurate contact details help us identify you and your medical records and allow us to contact you promptly about tests and results.

Title:	**Surname:**	**Given Names:**	
Date of Birth (dd/mm/yyyy):		**Gender:**	
Medicare number :		**Reference no:**	**Card expiry date:**
Concession card:		Circle -Pension/HCC:	Expiry date:
DVA Card Number:		Circle – Gold / White:	White Card Conditions:
Health insurance Yes ☐ No ☐ Name of fund:		Membership Number	
Defence Force members only – Service number		Rank	
Residential address		Suburb	Post Code
Postal address			Post code
Contact number (Home)	(Alternative)Must have:	(Mobile)	
Email address			
Occupation	Marital status		

NEXT OF KIN	**EMERGENCY CONTACT**
Name	Name
Relationship to Patient	Relationship to Patient
Address	Address
Phone Number	Phone Number

SECTION A: PERSONAL DETAILS

Yes ☐ No ☐

Do you have an advance health directive?

SECTION B: CULTURAL BACKGROUND

Knowing your cultural background can help us provide healthcare that meets your individual needs.

Are you of Aboriginal or Torres Strait Islander origin?			
No ☐	Aboriginal ☐	Torres Strait Islander ☐	Aboriginal and Torres Strait Islander ☐

Other cultural background (e.g. Mediterranean, Asian, African, Indian)			Country of Birth		
Is English your first language?	Yes ☐	No ☐	If no, do you require an interpreter?	Yes ☐	No ☐

Please specify language	

SECTION C: ALLERGIES AND MEDICINES

List allergies and intolerances to medications	Describe your reaction	Mild	Moderate	Severe
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐

Please circle below
Are you a smoker: Yes No
Do you consume Alcohol: Yes No

SECTION D: CONSENT:

We require your consent to collect personal information about you. Please read this information carefully and sign where indicated below.

This medical practice collects information from you for providing equality in health care. During the consultation, your doctor may ask your personal details and a full medical history, so we may properly access, diagnose, treat and be proactive in your health care needs. This means we may use the information you provide in the following ways:

- 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 the medical practice. This may occur through referral to other Doctors, for pathology and x-ray, in the reports, or results returned to us following the referrals
- Disclosure to other Doctors in the practice, Locums, Registrars, or Medical students attached to the practice for patient care and teaching. Please let us know if you do not want your records assessed for these purposes, and we will note this on your record accordingly.
- Disclosure to a medical legal defence organisation if a medico-legal issue arises
- Pap Smear registry
- Australian Childhood Immunisation Register
- Family cancer register

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 information requested of me, but my failure to do so may compromise the quality of health care and treatment given to me.

I am aware of my right to access information collected about me, except in some circumstances where access might be legitimately withheld. I understand that I will be given an explanation in those circumstances.

I understand that if my information is to be used for any other purposes other than those set out above, subject to any limitations, access, or disclosure, that I notify the practice.

We also need consent to allow us to either SMS or Email you as required.

Yes	No

Please Circle

How did you hear about us? Please Tick.

Bulletin	Facebook	Google	Other (Please specify)

I understand that if I fail to attend any booked appointment without contacting the practice, I may be charged a cancellation fee. This will be required to be paid at the time of the next consultation.

Signed: _____ Date: ____/_____/_____

Patient's Name: _____ DOB: ____/_____/_____

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PREVIOUS MEDICAL HISTORY	DATE IF KNOWN

PREVIOUS MEDICAL SURGERIES	DATE IF KNOWN

Please write on back if need more room