McKinnon Hill Medical Centre

# New Patient Information Form

*We need this information to provide the best quality care. This form complies with the Royal Australian College of GP's (RACGP) standards for general practice. This means your personal health information is kept private and secure, as required by federal and state privacy laws. If you have concerns, please leave blank and discuss with your GP.*

## Personal Details:

Title: _____ Surname: _____ First Name(s): _____

Date of Birth: ____/_____/_____ Gender: Male ☐ Female ☐ Neutral ☐ Other ☐

Address: _____ _____

Suburb: _____ Post Code: _____

Phone: (H) _____ (W) _____ (Mobile) _____

**Consent to send SMS messages** ☐ For appointment reminders & messages. Email: _____

Medicare No.: _____ Ref. on card: _____ Expiry: _____

Health Fund: _____ Member No.: _____

Pension Card/Health Care Card Number: _____Expiry: _____

DVA File No.: (if applicable) _____

Occupation: _____

## Emergency Contact:

Full Name: _____ Relationship to you: _____

Phone: (H) _____ (W) _____ (Mobile) _____

## Next of Kin

Full Name: _____ Relationship to you: _____

Phone: (H) _____ (W) _____ (Mobile) _____

## Cultural Background:

*Knowing your cultural background can help us provide healthcare that meets your individual needs.*
*There may be Commonwealth programmes that can assist us in your healthcare.*

Are you of Aboriginal or Torres Strait Islander descent? (please tick)

No ☐ Yes Aboriginal ☐ Yes Torres Strait Islander ☐ Yes both Aboriginal & Torres Strait Islander ☐

Are you registered fo CTG? ☐

Other Cultural Background (Mediterranean, Asian, African) _____

Country of Birth: _____

Is English your first language? Yes ☐ No ☐

If not, do you require us to provide an interpreter? Yes ☐ No ☐ Please specify language _____

## Allergies: Nil Known ☐

| List Allergies & Intolerances to Medications | Describe your reaction |
|---|---|
| | |
| | |
| | |
| | |

**Please turn over**

Do you have a usual Pharmacist? _____

**Current Medication:** _____

_____

**Significant Health Problems, Current:** _____

_____

**Significant Health Problems, Past:** _____

_____

## ▶ Social & Family History:

Alcohol Intake: Nil ☐ Yes ☐ Days per week: _____ Drinks per day: _____

Smoking History: Non Smoker ☐ Ex-Smoker ☐ Smoker ☐

## ▶ Significant Family History:

**Mother:**

Diabetes ☐ Hypertension ☐ Heart Disease ☐ Colon Cancer ☐

Stroke ☐ Depression ☐ Breast Cancer ☐ Other ☐ _____

Mother Alive? Yes ☐ No ☐ Age of Death _____ Cause of Death _____

**Father:**

Diabetes ☐ Hypertension ☐ Heart Disease ☐ Colon Cancer ☐

Stroke ☐ Depression ☐ Breast Cancer ☐ Other ☐ _____

Father Alive? Yes ☐ No ☐ Age of Death _____ Cause of Death _____

## Collection Statement and Privacy Consent

*For the primary purpose of providing you with the best quality care, we need to collect personal information about you (including your health information and sensitive information). Your information will enable us to thoroughly assess, diagnose and provide appropriate treatment to you. If you do not provide this information to us, we may not be able to treat you.*

The personal information which we collect will also be used for:

- administrative purpose;
- clinical information will be captured to facilitate the best possible treatment for your holistic health care.
- billing purposes (either directly or through an insurer or compensation agency);
- use within the practice with practice staff, other doctors for your ongoing treatment;
- disclosure to other doctors and health professionals outside the practice involved in your healthcare;
- research, quality assurance activities and teaching purposes where de identified information is used;
- In the case of insurance or compensation claim it may be necessary to disclose and/or collect information that concerns your return to work to an insurer, your lawyer and/or your employer;
- for follow up reminders/recalls which may be sent to you regarding your health care and management;
- disclosure legally required by law, such as notifiable disease;
- where you are unable to act on your own behalf due to a health condition, we may need to discuss your health information with relatives or emergency contacts, in order that you are provided with appropriate care;
- direct marketing purposes (you may opt-out of direct marketing at any time by notifying the Practice in a letter or email);

We do not disclose your personal information to overseas recipients.

Our practice uses a reminder and recall system to help you maintain your health. The practice sends reminders by post, telephone or text messaging/sms for immunisations, procedures and other health reviews as well as recalling for abnormal results and follow up requested by consultants and hospital discharges.

Our full Privacy Policy is available on request in the waiting area and on our website. That policy provides guidelines on the collection, use, disclosure and security of your information. The Privacy Policy contains information on how you may request access to, and correction of, your personal information and how you may complain about a breach of your privacy and how we will deal with such a complaint.

### ▶ Consent:

Signature of Patient or Guardian _____

Print Name _____ Date ____/ _____/ _____

**Please notify us promptly of any changes in your contact details. Accurate contact details help us identify you and your medical records, and allows us to contact you promptly about tests and results.**

### ▶ How did you hear about us? (please tick)

Advertisements: Local Newspaper ☐ Letter Box Drop ☐ Billboard ☐

Advertising/Sponsorship ☐ Travelled past Practice (car/bus/walk) ☐

Word of Mouth ☐ Website Search ☐ Family /Friend referral ☐

Other: ☐ (please specify)_____

**You will need the latest version of Acrobat Reader to submit this form online. Alternatively, you may also fill up this form online, download it as a PDF, and email us at **info@mckinnonhillmc.com.au**

Submit