

New Patient Information Form

We are committed to providing our patients with the best care. To do this, it is essential that your health record contains complete and accurate information. Please assist us by completing your new patient record form:

Contact Information

| | |
|---|--|
| Gender: | |
| Pronouns: | |
| Title: | |
| Surname: | |
| First Name: | |
| Date of Birth: | |
| Street Address: | |
| Postal Address: <i>(if different to above)</i> | |
| Home Phone: | |
| Work Phone: | |
| Mobile Phone: | |
| Email: | |

Emergency Contact Details

| | |
|---------------|----------------------|
| Name: | Relationship to you: |
| Home Phone: | |
| Mobile Phone: | |

Next of Kin

| | |
|---------------|----------------------|
| Name: | Relationship to you: |
| Home Phone: | |
| Mobile Phone: | |

Healthcare Identifiers

Medicare Number: _____ Ref: _____ Expiry: ____ ____

Dept. of Veterans' Affairs File Number: _____ o Gold o White

Concession (Pension/Health Care) Card Number: _____ Expiry: ____ ____

Cultural Identity

Are you Aboriginal _____ Are you Torres Strait Islander? _____

If yes, please advise your Nation

Nation/s _____

Australia is genuinely a multicultural society and in order to tailor appropriate care, encourage understanding and appreciation between people from different nationalities and cultures - do you identify as someone from a culturally and/or linguistic diverse background? No _____

If Yes - Please elaborate _____

If yes, do you require an interpreter service? No _____ Yes _____

Your Health Information

ALLERGY INFORMATION - Do you have any allergies or are you sensitive to drugs or dressings?

No _____ If Yes – please provide details: _____

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.)

MEDICAL HISTORY - Do you have, or have you had a history of the following? (Please tick relevant ones)

- Surgery – provide details: _____
- Asthma Diabetes Hypertension Chronic Illness
- Other, provide details: _____

LIFESTYLE RISK FACTOR INFORMATION (please tick):

Smoking

- No Ceased – date _____
- Yes - how many _____ day / _____ week

Alcohol

- No Yes - how many _____ day / _____ week / _____ month

Recreational Drug Use

- No Yes - type _____ frequency _____

Family Health History Information

Have any members of your family have/had (please tick):

- Heart Disease Asthma
- Diabetes Hypertension (high blood pressure)
- Mental Illness Cancer – type: _____
- Other significant - provide details: _____

Patient Consent: Collecting Information

Please read this consent form carefully prior to signing

Yerrabi Health 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 and treat illnesses and medical conditions, ensuring we are proactive in your health care. To enable ongoing care, and in keeping with the *Privacy Act 1988* and *Australian Privacy Principles*, we wish to provide you with sufficient information on how your personal information may be used or disclosed and record your consent or restrictions to this consent.

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

The information we collect may be collected by a number of different methods and examples 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/guardian) are consenting to the collection of your personal information, and that it may be used or disclosed by the practice for the following purposes:

- Administrative purposes in the operation of our general practice.
- Billing purposes, including compliance with Medicare requirements.
- Follow-up reminder/recall notices for treatment and preventative healthcare, frequently issued by SMS.
- Disclosure to others 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 us following the referrals.
- Accreditation and quality assurance activities to improve individual and community health care and practice management.
- For legal related disclosure as required by a court of law.
- For the purposes of research only where de-identified information is used.
- To allow medical students and staff to participate in medical training/teaching using only de- identified information.
- To comply with any legislative or regulatory requirements, e.g. notifiable diseases.
- For use when seeking treatment by other doctors in this practice.



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

Your records are very important, and we will take all steps necessary to ensure they remain confidential. Please complete the form below if you understand and agree to the following statements in relation to our use, collection, privacy and disclosure of your patient information.

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, _____ 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)

Signature: _____

Date: _____

If not patient signing - your name (please print) _____

Your relationship to the patient (e.g. Mother, Father, guardian) _____

PRACTICE USE ONLY:

Witnessed by: (staff signature) _____

Patient Consent: Using Emails

Yerrabi Yurwang is committed to patient privacy and ensuring all health information is safe and secure. The use of unencrypted and unsecured email can create risks to the privacy and security of personal and sensitive health information.

Although the practice prefers to use paper-based communication or secure messaging, it understands that this is not always possible. To cater for this, the practice allows a for the use of email to send information of documents to patients.

Note: Not everything can be sent via email, and this is at the GP's discretion. Please discuss it with your doctor.

Before Yerrabi Health Hub can release information, it is important you understand the risks.

The risks of using unsecured or unencrypted email include:

- emails can easily be sent to the wrong recipient
- email is often accessed on portable devices, such as smart phones, tablets and laptops, which are easily lost or stolen
- emails can be forwarded or changed without the knowledge or consent of the original sender
- email is vulnerable to interception.

Patient name: (please print)

Signature: _____

Date: _____

If not patient signing - your name (please print) _____

Your relationship to the patient (e.g. Mother, Father, guardian) _____

PRACTICE USE ONLY:

Witnessed by: (staff signature) _____