James St Medical

Title	**Mr** **Mrs** **Ms** **Miss** **Master** **Dr**				
Surname					
First Name/s		**Middle name**		**Known as**	
Date of Birth					
Street Address					
Post Code					
PLEASE TICK ONE: ***To assist with health initiatives – Do you identify as:***	☐ Aboriginal ☐ Torres Strait Islander ☐ Both Aboriginal & Torres Strait Islander ☐ Australian (non-indigenous) ☐ Other (please specify) _____				
Home Phone					
Work Phone					
Mobile Phone	**Consent to SMS reminders :** Y / N				
Email					
Medicare Number			**Expiry Date**	**Reference number (left of name)**	
DVA Gold / White (Please circle)			**Expiry Date**		
Pension Number			**Expiry Date**		
Health Care Card Number			**Expiry Date**		
Private Health Cover	Member Number:				
Next of Kin	Name: Phone number: Relationship:				
Emergency Contact	Name: Phone number: Relationship:				
Occupation					

HOW DID YOU HEAR ABOUT OUR SURGERY? Friend & Relative / Internet / Signage / Others ……

If we need to contact you what is your preferred method of contact:

☐ Home phone ☐ Mobile phone ☐ Mail ☐ Email

DATE: _____

James St Medical

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

This medical 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 proactive 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 and Health Insurance Commission requirements.
- 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.
- Disclosure to other doctors in the practice and locums for the purpose of patient care. Please let us know if you do not want your records accessed for this purpose and will note your record accordingly.
- Disclosure for research and quality assurance activities to improve individual and community health care and practice management. You will be informed when such activities are being conducted and given the opportunity to "opt out" of any involvement.

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 and if I have not attended, my records will be destroyed by incineration after 7 years.

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 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 purpose other than set out above, my further consent will be obtained.

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

SURNAME: _____FIRSTNAME: _____

Signed: …… (Patient) Date: ……

Should you have any concerns regarding a breach of your privacy, please contact our Practice Manager or your Doctor. If you wish to take the matter further and feel that you need to discuss the matter outside the surgery, the Health Rights Commission may be contacted on 3234 0333.

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SURNAME: _____FIRSTNAME: _____
ALL following clinical information is required in order for our practice to meet accreditation standards.

Marital Status: Single/ Married/ Divorced/ Widowed/ De facto (circle the one applicable)
☐ Do you identify as a member of the LGBTI (lesbian, gay, bisexual, transgender or intersex) community Yes / No

Please state **how many per day:**
☐ Tobacco – Y / N _____(how many **per day**)
☐ Alcohol – Y / N _____(how many **per day**)
☐ Drug use – Y / N _____ (type & frequency)

Height: _____ cms **Weight:** _____ kgs **Waist**: _____ cm
*If you do not know your waist circumference there is a measuring tape in the **restroom and at reception** for your use or ask your GP to take the measurement during your consult.

Do you have any allergies?
☐ Yes (If yes please list below **& your reaction**) ☐ No

_____

_____

Date of last PAP smear & result – *(if you do not know or have not had one please state so, we can look it up for you)*
_____

Please list any current or previous medical conditions or previous operations
_____

_____

_____

_____

Current medications & dosage if known.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Family history – Do you have any family history of medical conditions including heart disease, stroke, mental illness or cancers? If yes who and what illness did they have? If no please state so.
_____
_____
_____