**New Patient Information Form**

Welcome to our practice! We are committed to providing our patients with the best care. To do this it is essential that your health record is kept up to date and is accurate. Could you please assist us by completing the following information.

|  |  |
| --- | --- |
| Title (please circle) | Dr. Mr. Mrs. Ms. Miss Mast Other: |
| Surname |  |
| Given Names |  |
| Birth Sex (please circle) | Male Female Other: Prefer not to disclose |
| Gender (please circle) | Male Female Other: Prefer not to disclose |
| Date of Birth |  |
| Country of Birth |   |
| Do you identify as (please circle): Aboriginal origin? Torres Strait Islander origin?  |
| Street Address |  Suburb: aaaaaaaaaaaaa Post Code: aaaaaaaaaa  |
| Postal Address  |  |
| Home Phone Number |  | Work Phone Number |  |
| Mobile |  |
| Email |  |
| Occupation |  |
| Do you consent to receiving text messages? | Yes No |
| Medicare Details | Card No.: IRN: Exp.: |
| DVA Number |  White Gold Card No.: Exp.: |
| Pension Number | Card No.: Exp.: |
| Next of Kin | Name: Relationship:Contact Number:  |
| Emergency Contact | Name: Relationship:Contact Number: |
| Payer of Account for Child Under 17yrs old. | Name: Date of Birth:Medicare Card #: IRN: Exp.: Relationship:  |

**Patient Consent**

**The purpose of this form is to inform you and seek your consent to the use and disclosure of your personal information (including health information) in regards to our reminders and notifications systems within our practice.**

*Carina Medical and Specialist Centre is committed to providing our patients with quality health care. As part of our commitment, we have implemented technology solutions to enable communications with our patients via SMS. Your doctor in the course of a consultation may ask personal details and a full medical history so that he/she may properly assess, diagnose, treat and be proactive in your health care needs.*

*In keeping with our obligations under Privacy Act 1988 (Cth) and Australian Privacy Principles and under State and Territory health records legislation, we wish to inform you of the purposes for which we may use your personal information and how we may use and disclose your personal information (including health information).*

*As part of the provision of health care services to you, we will send you appointment reminders, clinical reminders and clinical communications. We may also send you health awareness information if you have consented to receive such communications.*

* ***appointment reminders*** *– notifications to you to remind you of upcoming appointment dates with the practice as well as allowing you to confirm your appointment;*
* ***clinical reminders*** *- notifications to you* *to remind you to contact the practice to arrange appointments for regular clinical check-ups, medical procedures, immunisations due;*
* ***clinical communications*** *- communications to you about your clinical care at the practice such as returned pathology results or clinical messages from the medical practitioner; and*
* ***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.*

**Acknowledgements and Consent**

I acknowledge and agree that, in the course of providing health care services to me, Carina Medical and Specialist Centre may need to use and disclose my personal information (including any health information) as set out in this form.

I acknowledge that the practice will use contact details provided by me (as updated by me) to communicate with me. To the extent that the mobile number I have provided is utilised by more than one patient, I understand and consent that all SMS and phone communications will be directed to that number.

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

|  |  |  |  |
| --- | --- | --- | --- |
| Patient Name: |  |  |  |
| Parent/Guardian Name (if Patient is under 16) |  |  |  |
| Signature: |  | Date: |  |

**Patient Health History**

**Name: DOB:**

To assist us with ensuring that your medical record is accurate, please complete the following medical questionnaire.

|  |
| --- |
| **Significant Medical History**Please list any significant medical history such as chronic diseases, surgical procedures, mental health conditions, and other health conditions. |
|  |
| **Current Medication**Please list ALL tablets, patches, inhalers, gels, creams, injections, supplements, or homeopathic remedies you currently take or use.  |
| **Name of Medication** | **Dosage** |
|  |  |
|  |  |
|  |  |
|  |  |
| **Allergies**Do you have any allergies or sensitivities to any medications or fibre materials?  |
| **Yes (please specify)** | **No** |
| Medication/Fibre | Type of Reaction |
|  |  |
|  |  |
| **Smoking History (please circle)** |
| Non- Smoker Smoker Ex-Smoker |
| **Alcohol (please circle)** |
| Nil | Occasionally | Moderate | Heavy |
| **Family History**Does anyone in your family have a history of the following? |
| Diabetes Hypertension Heart DiseaseDepression Stroke Breast Cancer Prostate CancerOther Cancers (please specify): |
| Mother deceased? | Yes No | Age of Death: | Cause: |
| Father deceased? | Yes No | Age of Death: | Cause: |