Date: ___/___/___

NEW PATIENT INFORMATION

Please complete this form in as much detail as possible.
This will assist our team to provide the best possible care for you and your family.
Please ask either the reception staff or our practice nurse, if you have any questions.

TITLE:		**SURNAME:**		**FIRST NAME:**		**DATE OF BIRTH:**	

ADDRESS:			
E-MAIL:			
OCCUPATION:			**SMS Appt Reminder** ☐
PHONE NO: HOME:	**WORK:**	**MOBILE:**	

MEDICARE NUM:	**REFERENCE NUM:**	**EXPIRY DATE:**
PENSION/HCC:	**GRANT DATE:**	**EXPIRY DATE:**

NEXT OF KIN (NOK)	**EMERGENCY CONTACT (if different from NOK)**
NAME:	NAME:
PHONE # - home:	PHONE # - home:
PHONE # - mobile/work:	PHONE # - mobile/work:
RELATIONSHIP:	RELATIONSHIP:

Do you give permission for staff to tell others in your household, where we are calling from?	YES	NO
	Please sign:	

Please note – This is indefinite until you inform us otherwise.

Ethnicity – What is your ethnicity / where were you born?		
Do you identify as Aboriginal or Torres Strait Islander descent?	YES	NO

How did you hear about us?

- ☐ Signage (Walking Passed)
- ☐ Internet search
- ☐ By clicking on a Google Display Ad
- ☐ Yellow Pages online
- ☐ Our Website (www.advocatemc.com.au)
- ☐ Yellow Pages (book)
- ☐ News paper Ads
- ☐ Other Doctor
- ☐ Family/Friends
- ☐ Letter drop
- ☐ School
- ☐ Pharmacy
- ☐ Other (please specify) _____

The material sent by mail will consist of items such as recall letters and reminders for things such as pathology tests and routine checks & pap smears.
From time to time we may also send you general information regarding the medical centre.
You may unsubscribe from this service at any time by notifying the reception team.

Please note that your phone number will remain confidential at all times

Thank you for helping us to provide you with better care

Date: ____/____/____

NEW PATIENT INFORMATION

Please complete this form in as much detail as possible.
This will assist our team to provide the best possible care for you and your family.
Please ask either the reception staff or our practice nurse, if you have any questions.

TITLE:		SURNAME:		FIRST NAME:		DATE OF BIRTH:	

ALLERGIES: Please list any medication allergies		No Known Allergies – Tick this box	

MEDICATIONS: Please list ALL current medications, including the contraceptive pill & any "over the counter" or "natural" medications	Medication Name	Dose	Frequency	Medication Name	Dose	Frequency

PAST HISTORY: Please provide details of any previous illnesses, operations or significant health problems		

FAMILY HISTORY: Please list any important medical conditions affecting members of your family. (eg cancer, diabetes, high blood pressure etc)	Diabetes		Depression	
	High Blood Pressure		Breast Cancer	
	Heart Disease		Prostate Cancer	
	Stroke		Other	
	Colon Cancer			

SMOKING: (Cigarettes) Please answer as accurately as you can	NO	Never Smoked	
	YES	Cigarettes per day on average?	
	EX-SMOKER	How long ago did you stop?	
		How many a day did you smoke?	

If you would like assistance changing your smoking habit please speak to your GP

ALCOHOL: Please answer as accurately as you can	NO	Never drink			
	YES	Days drinking alcohol per week		Drinks per night	
		Average total standard drinks per week			

EXERCISE: Please answer as accurately as you can	Do you do any regular exercise?	YES	NO
	If yes, how much exercise do you do and how often?		

WOMEN ONLY:	Have you ever been pregnant?	
	If yes, how many times (in total)?	
	How many children do you have?	
	When was your last pap smear?	
	When was your last mammogram? (if over 40)	

ADVOCATE MEDICAL GROUP

Health Information Collection and Use Consent Form

As a patient of our medical group 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.

We aim to protect the privacy and secure storage of your health information. You can request a copy of our privacy policy, which includes information about the collection, use and disclosure of your health information.

We require your consent to collect personal information about you and to use the information you provide in the following ways. Please read this consent form carefully, and sign where indicated below.

- 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 this medical group. This may occur though referral to other doctors, or for medical tests and in the reports or results returned to us following referrals.
- Disclosure to other doctors in the group, locums etc. attached to the group for the purpose of patient care and teaching.
- For research and quality assurance activities to improve individual and community health care and practice management. Usually information that does not identify you is used but should information that will identify you be required you will be informed and given the opportunity to "opt out" of any involvement.
- To comply with any legislative or regulatory requirements e.g. notifiable diseases.
- For reminder letters which may be sent to you regarding your health care and management.

You can decline to have your health information used in all or some of the ways outlined above but it may influence our ability to manage your health care to provide the best outcome for you.

I have read the information above and understand the reasons why my information must be collected.	
I understand that I am not obliged to provide any information requested of me, but failure to do so may compromise the quality of health care and treatment given to me.	
I am aware of my rights to access the information collected about me, except in some circumstances where access may be legitimately withheld. I will be given an explanation in these circumstances.	
I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.	
I consent to the handling of my information by the group for the purpose set out above, subject to any limitations on access or disclosure of which I notify this group.	
OR	
I am unsure and would like to discuss this further with someone from the medical group before I sign.	

Patients Name_____ Date_____/_____/_____

Patient's signature_____

Signed as Guardian for child_____ Name (printed) _____