NEW PATIENT INFORMATION

Prospect Medical Centre
HEALTHCARE FOR LIFE

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 accurate.
Could you please assist us by completing the following:

Title: Mr Ms Mrs Miss Master

Family Name:

Given Name:

Middle Name:

Preferred Name:

Date of Birth: ☐☐/☐☐/☐☐☐☐

Sex: ☐ Female ☐ Male ☐ Other ☐ Unknown

Ethnicity: ☐ Australian, Non Indigenous

☐ Other Details :

To assist with health initiatives - are you Aboriginal or Torres Strait Islander?

☐ Yes ☐ No Neither

☐ Aboriginal

☐ Torres Strait Islander

☐ Both Aboriginal & Torres Strait Islander

Address:

Suburb: Post Code:

Postal:

Suburb: Post Code:

Home Ph: ☐☐ ☐☐☐☐ ☐☐☐☐

Mobile : ☐☐☐☐ ☐☐☐ ☐☐☐

Would you like to receive SMS reminders 24 hours before your appointments? ☐ Yes ☐ No

Email address:

@

Medicare Card Number:

☐☐☐☐ ☐☐☐☐☐ ☐

Reference Number: Expiry Date:

☐ ☐☐/☐☐☐☐

☐ Pensioner Concession Card

☐ Commonwealth Seniors Health Care Card

☐ Health Care Card

☐ DVA ☐ Gold ☐ White ☐ Orange

Number:

☐☐☐☐☐☐☐☐☐☐

Expiry Date:

☐☐/☐☐/☐☐☐☐

Private Health Insurance:

☐ Medibank ☐ St Lukes ☐ Bupa

☐ Other

Next of Kin:

Name:

Contact:

Relationship:

Emergency Contact:

Name:

Contact:

Relationship:

Your Occupation:

HEALTH INFORMATION COLLECTION AND USE CONSENT FORM

As a patient of our medical practice 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 practice. 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, nurses, Medical students, Allied Health Care Professionals in the practice, and locums attached to the practice for the purpose of patient care and teaching and to fulfill their duties in the course of managing my health care planning and management of my health.
- For research and quality assurance activities to improve individual and community health care and practice management.
- 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.

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 practice for the purpose set out above, subject to any limitations on access or disclosure of which I notify this practice.

Patient's name:

DOB ☐☐/☐☐/☐☐☐☐

Patient's signature

Date: ☐☐/☐☐/☐☐☐☐

Signed as Guardian for child

Name: (printed)

I confirm that the information I have given (on this form) is correct.

Revised Jan 2019

Patient Name: _____ Date of Birth: ☐☐/☐☐/☐☐☐☐

Nurses

Immunisations – have you had the following immunisations?

Tetanus Booster:	Date: ☐☐/☐☐/☐☐☐☐	Don't Know: ☐	Haven't Had One: ☐
Hepatitis B:	Date: ☐☐/☐☐/☐☐☐☐	Don't Know: ☐	Haven't Had One: ☐
Hepatitis A:	Date: ☐☐/☐☐/☐☐☐☐	Don't Know: ☐	Haven't Had One: ☐
Influenza:	Date: ☐☐/☐☐/☐☐☐☐	Don't Know: ☐	Haven't Had One: ☐
Pneumococcal:	Date: ☐☐/☐☐/☐☐☐☐	Don't Know: ☐	Haven't Had One: ☐
Polio:	Date: ☐☐/☐☐/☐☐☐☐	Don't Know: ☐	Haven't Had One: ☐
Other:	Date: ☐☐/☐☐/☐☐☐☐	Don't Know: ☐	Haven't Had One: ☐

For those 65 years and older: when was the last time you were immunised?

Influenza:	Date: ☐☐/☐☐/☐☐☐☐	Don't Know: ☐	Haven't Had One: ☐
Pneumococcal Pneumonia:	Date: ☐☐/☐☐/☐☐☐☐	Don't Know: ☐	Haven't Had One: ☐

Females: When did you last have?

Pap Smear:	Date: ☐☐/☐☐/☐☐☐☐	Don't Know: ☐	Haven't Had One: ☐
Breast Check:	Date: ☐☐/☐☐/☐☐☐☐	Don't Know: ☐	Haven't Had One: ☐

Males: When did you last have?

An overall check up:	Date: ☐☐/☐☐/☐☐☐☐	Don't Know: ☐	Haven't Had One: ☐

Children's Immunisations – if completing this form for a child are their immunisations up to date?

Yes ☐ No ☐

Social History:

Smoker: ☐ Non Smoker ☐ Drinker ☐ Non Drinker ☐

Tobacco: ☐ Per Day/Week Or Ceased Smoking on ☐☐/☐☐/☐☐☐☐

Alcohol: ☐ Per Day/Week/Month (circle applicable)

Drug Use: _____ (Type and Frequency)

Height: _____ cms **Weight**: _____ kgs (if known)

Blood Pressure: When was the last time your blood pressure was taken? _____

Children under 16: Are there any

Parenting Orders Yes ☐ If yes **Please Provide Copies** No ☐

Guardianship Orders Yes ☐ If yes **Please Provide Copies** No ☐

Revised Jan 2019

Patient Name: Date of Birth: / /

Doctors

Your Health History – Do you have or have you had a history of:

Operations When: / /

When: / /

When: / /

When: / /

				Details
Asthma	Yes		No	
Diabetes	Yes		No	
Hypertension	Yes		No	
Chronic Illness	Yes		No	
Other	Yes		No	

Allergies - Do you have any Allergies or are you sensitive to drugs or dressings:

Yes If yes, please list below No

Allergy (ie: Penicillin, Latex, etc)	Reaction (ie: Anaphylaxis, Rash, etc)

Current Medications – Including over the counter medications, vitamins and minerals:

Yes If yes, please list below No

Sun Protection:

How often do you use the following to protect yourself from the sun when outdoors?

	Always	Often	Sometimes	Rarely	Never
Protective Clothing					
Sunscreen					

Patient Name: Date of Birth: / /

Doctors

Family History – Have any members of your family had:

			Relationship for you/Details
Diabetes	Yes ☐	No ☐	
Asthma	Yes ☐	No ☐	
Heart Disease	Yes ☐	No ☐	
Mental Illness	Yes ☐	No ☐	
Cancer	Yes ☐	No ☐	
Other	Yes ☐	No ☐	

My Health Record - Do you have a My Health Record :

Yes ☐ No ☐

Additional information for your GP: