GARDENS MEDICAL GROUP

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:	☐ Male ☐ Female ☐ Intersex ☐ Transgender ☐ Other:
Title:	
Surname:	
First Name:	
Date of Birth:	
Street Address:	
Postal Address: *(if different to above)*	
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: ______________________________________ ☐ Gold ☐ White

Concession (Pension/Health Care) Card Number: _____________________________ Expiry: ___/_______

Cultural Identity

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

☐ No ☐ Yes – Aboriginal ☐ Yes - Torres Strait Islander ☐ Yes - Aboriginal and Torres Strait Islander

As Australia is a genuinely multicultural society, and 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

☐ Yes - Please elaborate ____

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

GARDENS MEDICAL GROUP

Checking in

It is essential when arriving for your appointments to check in. You can do this by using the Kiosks located next to the lifts, or checking in with the Arrivals Desk or Receptions 1or 2.

Reminder Systems

Our practice provides our patients with preventative care and early case detection reminders e.g. immunisations, annual health checks, skin checks and pap smears.

Do you wish to have any relevant health reminders sent to you?

☐ Yes – Mail
☐ Yes – Email at this address ____
☐ Yes – SMS to the number ____
☐ No

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

☐ Home Phone
☐ Mobile Phone/ SMS Message
☐ Mail
☐ Email

Do you have any health concerns that you would like to receive more information on?

Patient Consent

Signature:
Date:

GARDENS MEDICAL GROUP

Date: ______________________________

Name: ______________________________

Date of Birth: ______________________________

Your Health History

Do you have or have you had a history of the following? (please elaborate)

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

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

- ☐ No
- ☐ Yes. Please elaborate:

Immunisations

Have you had the following immunisations? (list date where appropriate)

Tetanus Booster	☐ Yes. Date:	☐ No	☐ Don't Know
Hepatitis B	☐ Yes. Date:	☐ No	☐ Don't Know
Hepatitis A	☐ Yes. Date:	☐ No	☐ Don't Know
Influenza	☐ Yes. Date:	☐ No	☐ Don't Know
Pneumococcal	☐ Yes. Date:	☐ No	☐ Don't Know
Polio	☐ Yes. Date:	☐ No	☐ Don't Know

Children's Immunisations

If completing this form for a child are their immunisations up to date?

- ☐ Yes
- ☐ No

Current Medications

Please list all current medications including over the counter medications, vitamins and minerals:

Family History

Have any members of your family had: (please elaborate)

- ☐ Heart Disease
- ☐ Asthma
- ☐ Diabetes
- ☐ Hypertension
- ☐ Mental Illness
- ☐ Cancer
- ☐ Other significant: provide details:

GMG
GARDENS MEDICAL GROUP

Social History

Do you use any of the following: (list amount where appropriate)	
Tobacco	☐ No. ☐ Yes. Number ____ day / ____ week **or** ☐ Ceased smoking
Alcohol	☐ No. ☐ Yes. Number ____ day / ____ week / ____ month
Recreational Drug Use	☐ No. ☐ Yes. Type __________________ / Frequency __________________

Measurements

Height	_________ cm
Weight	_________ kg

Blood Pressure

When was the last time your blood pressure was taken?

Sun Protection

How often do you use the following to protect yourself from the sun when outdoors?					
Protective clothing	☐ Always	☐ Often	☐ Sometimes	☐ Rarely	☐ Never
Sunscreen creams	☐ Always	☐ Often	☐ Sometimes	☐ Rarely	☐ Never

For those 65 years and older:

When was the last time you were immunised?			
Influenza	Date:	☐ Not sure	☐ Never
Pneumococcal pneumonia	Date:	☐ Not sure	☐ Never

Females

When did you last have?			
Pap Smear	Date:	☐ Not sure	☐ Never
Breast Check	Date:	☐ Not sure	☐ Never

Males

When did you last have?			
Overall Checkup	Date:	☐ Not sure	☐ Never

GMG

GARDENS MEDICAL GROUP

Patient Consent

Please read this consent form carefully prior to signing.

This 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 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.

If I am between the ages of 14-18 years I give my parents consent to access information regarding my health ☐ Yes ☐ No

Patient name: (please print) ____

Signature: ____ Date:_________________________________

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

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

PRACTICE USE ONLY:

Witnessed by: (staff signature)____