GARDENS MEDICAL GROUP

Level 3, 470 Wodonga Place
Albury Nsw 2640
Ph: 02 6021 3555
Fax: 02 6021 7161
Email: gmg@thegardensmedical.com.au

PATIENT INFORMATION FORM

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** **Mrs** **Ms** **Miss**		
Surname			
First Name			
Date of Birth			
Street Address			
Suburb and Post Code			
Home Phone			
Work Phone			
Mobile Phone			
Email			
Medicare Number & Ref		**Expiry Date**	
DVA Gold / White (Please circle)		**Expiry Date**	
Pension Number		**Expiry Date**	
Health Care Card Number		**Expiry Date**	
Private Health Cover			
Next of Kin (Name and Telephone number)	**Relationship:**		
Emergency Contact	(Name and Telephone number of the person we can contact if needed) **Relationship:**		
Employer Name			
Employer Address			
Employer telephone no.			

Checking In: It is essential when arriving for your appointments to check in at the Arrivals desk on the right when exiting the lift, at the check in booth or at either Reception 1 or 2.

Reminder Systems:

Our practice provides our patients with preventive 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 this phone 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?_____________________________________

Australia is a genuinely multicultural society. To tailor appropriate care, encourage understanding and appreciation between people from different nationalities and backgrounds –Do you identify as someone from a culturally and/or linguistic diverse background?

☐ Yes - Please elaborate -____

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

☐ Yes - Aboriginal ☐ Yes - Torres Strait Islander ☐ Yes - Aboriginal & Torres Strait Islander ☐ No

Patient Signature: ____ **Date:** __________________________________

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Date: ____________________
Name: ____________________
Date of Birth: ____________________

Your Health History

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

- ☐ Operations
- ☐ 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

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☐ Asthma
☐ Diabetes
☐ Mental Illness
☐ Cancer

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
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

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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 in the practice, locums etc. attached to the practice 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 practice for the purpose set out above, subject to any limitations on access or disclosure of which I notify this practice.	☐
If I am between the ages of 14- 18 years I give my parents consent to access information regarding my health.	☐
OR	
I am unsure and would like to discuss this further with someone from the medical practice before I sign.	☐

Date: ____

Patient’s name: ____

Patient’s signature: ____

Signed as Guardian for child: ____

Name: (printed) ____