Viewbank Family Medical Group

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www.viewbankmedicalcentre.com

NEW PATIENT FORM & CONSENT FORM

Personal Details

Title: (Circle) Dr, Mrs, Mr, Miss, Master, Ms
Gender identity: Male __ Female __ Transgender__ Other_____

Marital Status (circle): Single, Married, Engaged, Divorced, de facto, have a partner, widowed, other.....

Surname: _____ **First Name:** _____

Date of Birth: _____/_____/_____

Address: _____
Suburb: _____ **Post Code:** _____
Phone Home: _____ **Work:** _____
Mobile: _____
Email: _____

Medicare number: _____ **Expiry Date:** ____/_____ **Ref No.:** ____
Pension/Healthcare card number: _____ **Expiry:** ____/_____
Private Health Insurance:
Health Fund_____ **Members No.**_____
Veteran card: Gold / White (Please Circle) _____ **Expiry:** ____/_____

TAC/Work Cover Claim No. _____
Name of Insurer _____

Current Occupation: _____

Next Of Kin:
Name: _____
Contact No: _____
Mobile: _____
Relationship: _____

Emergency contact:
Name: _____
Contact No: _____
Mobile: _____
Relationship: _____

Cultural background

Knowing your cultural background can help us provide healthcare that meets your individual needs.

Are you Aboriginal or Torres Strait Islander origin? No ☐ Yes, Aboriginal ☐
☐ Yes, Torres Strait Islander ☐ Yes, both Aboriginal & Torres Strait Islander

Cultural background ☐ **Australian** Country of Birth

Other: **(e.g. European, Asian)**

Is English your first language? If not, do you require an interpreter? Please specify language

☐ Yes ☐ No Yes ☐ No ☐

Medical History

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

To what? _____ Reaction? _____

Current medications (including over the counter medication)

Name of medication	Strength	Times taken

Family History: e.g. Asthma, Hypertension, Diabetes, Heart/Stroke etc.

_____

_____

Social History	**Yes**	**No**	
Cigarette Smoker	☐	☐	____ per day, Quit date: _____
Alcohol	☐	☐	_____ Standard Drinks per week
Intravenous drugs	☐	☐	_____
Other drugs (marijuana)	☐	☐	_____

Exercise: **No. of 30 minutes of brisk walking or moderate physical activity per week**
1 2 3 4 5 6 7 days (please circle) Hours_____

Nutrition/Diet: Good/Average (please circle)

Height _____**cm** Weight _____**kg**

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 regarding your health care and management.
- Give permission for GP/Clinical staff to access patient file remotely from Rosanna Medical Group.

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.

Patients Name: _____ **Date:** ____/____/_____

Patients signature: _____

Signed as Parent/Guardian for child: _____

Name: (printed) _____