

# New Patient Form

Patient name \_\_\_\_\_

We need this information to provide the best quality care. Our practice follows the guidelines of The Royal Australian College of General Practitioners Handbook for the management of health information in private medical practice. This means your personal health information is kept private and secure, as required by federal and state privacy laws. If you have concerns, please leave blank and discuss with your GP. This form complies with the RACGP Standards for general practices.



## Patient's details

Title \_\_\_\_\_ Surname \_\_\_\_\_ Given names \_\_\_\_\_

Date of birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_  Male  Female

Marital status  Single  Married  De facto  Separated  Divorced  Widowed

Medicare number \_\_\_\_\_ Private health fund  Yes  No

Pension, Health Care Card, or Veterans Affairs number (if applicable) \_\_\_\_\_

Occupation \_\_\_\_\_

Home address \_\_\_\_\_

Postal address \_\_\_\_\_

Phone (home) \_\_\_\_\_ (work) \_\_\_\_\_ (mobile) \_\_\_\_\_

Email \_\_\_\_\_

## Emergency contact (Next of kin)

Name \_\_\_\_\_ Relationship to you \_\_\_\_\_

Phone (home) \_\_\_\_\_ (work) \_\_\_\_\_ (mobile) \_\_\_\_\_

Are you of Aboriginal or Torres Strait Islander origin?  No

Aboriginal  Torres Strait Islander  Aboriginal and Torres Strait Islander

List allergies and intolerances to medications \_\_\_\_\_

List regular medications and doses \_\_\_\_\_

Our practice undertakes research, professional development, and quality assurance/improvement activities to improve patient care. All people accessing personal health information for this purpose have signed a written confidentiality agreement.

I consent to my health record being reviewed as a part of the quality improvement activities at this practice.  Yes  No

Our practice uses a reminder system to improve the quality of your health care. The practice sends reminders by mail or telephone for procedures such as vaccinations, Pap tests and other health reviews.

I consent to being contacted with reminders as a part of the quality improvement activities at this practice.  Yes  No

Signature of patient or guardian \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Please advise us if your contact information or Medicare details change.

## TRANSFER OF HEALTH INFORMATION

You may have consistently consulted with a GP at another practice. The health information held by that GP may assist us with your future health care needs. You may wish to have a copy or a summary of your health records transferred to this practice. Please ask the receptionist for information about how this can take place.