LAKE MUNMORAH DOCTORS' SURGERY

Dr J Phillips Dr W Grennall Dr M Hood Dr J Webster Dr K Love Dr A Gray and Associates

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 up to date and accurate.

Could you please assist us by completing the following:

Title	☐ Dr ☐ Mr ☐ Rev ☐ 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:
☐ **DVA Gold** ☐ **DVA White** ☐ **DVA Orange**	#:	Expiry:
Pension Number	#:	Expiry:
Health Care Card Number	#:	Expiry:
Private Health Cover ☐ **Yes** ☐ **No**	Name:	#:

Next of Kin and relationship (Name and Telephone number)	
Emergency Contact (Name and Telephone number of the person we can contact if needed)	

Patient Background

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?

☐ No

☐ Yes. Please specifiy:……

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

☐ No

☐ Yes – Aboriginal BUT NOT Torres Strait Islander

☐ Yes - Torres Strait Islander BUT NOT Aboriginal

☐ Yes – Aboriginal & Torres Strait Islander

Employer Name	
Employer Address	
Employer telephone no.	

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 ☐ No

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

☐ Home Phone ☐ Mobile ☐ Mail

Are there any health concerns that you would like to receive information on?

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

☐ 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

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.

Please read this consent form carefully, and sign where indicated below. ***We require your consent*** to collect personal information about you and to use the information you provide in the following ways:

- 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 or text messages 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 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 ❒

OR

- I am unsure and would like to discuss this further with someone from the medical practice before I sign. ❒

Patient's name: **……**

Patient's signature: **…… Date: …./…../…..……**

Signed as Guardian for child: **……..**

Name: (printed) **……...**

WE ARE A PRIVATE BILLING PRACTICE.

<u>Identification required</u>

Please provide:

- **Medicare card**
- **Pension or Health Care Card**
- **Driver's Licence**
- **Or Passport if no Medicare Card.**