NARANGBA VALLEY MEDICAL CENTRE

# NEW PATIENT INFORMATION

We are committed to providing our patients with the best care possible, in order to do this, it is essential that your medical records are as up to date and accurate as possible.
Could you kindly assist us by completing this form with as much information as possible.

| | | | |
|---|---|---|---|
| Title (Please circle or complete details)<br>**Mr. Mrs. Ms. Miss Mast** | | | |
| First Name: | | Surname: | |
| Preferred Name: | | | |
| Date of Birth: | | Country of Birth:<br>Year of Arrival in Australia: | |
| Do you Identify as: (Please Tick) ☐ **Aboriginal** ☐ **Torres Strait Islander** ☐ **ATSI** ☐ **No** | | | |
| Street Address: | | | |
| Suburb: | | State: | Postcode: |
| Contact Numbers | H) | M)<br>**SMS notification** ☐ **Yes** ☐ **No** | W) |
| Email: | | | |
| Medicare Number: | _ _ _ _ _ _ _ _ _ _ _ Ref No: **1 2 3 4 5 6** (Circle)<br>Exp Date: | | |
| Gold DVA Number: | Exp Date: | | |
| White DVA Number: | Exp Date:<br>Specific Condition: ..... | | |
| Pension/Health Care Card Number | | Exp: | |
| Private Health Ins | ☐ No ☐ Yes ☐ Basic Hosp ☐ Intermediate ☐ Top Hosp | | |
| Occupation: | | | |
| Next of Kin:<br>(Person who you would like us to contact in case of an emergency) | Name:..... Contact No:.....<br>Relationship to you:..... (eg. Mother) | | |
| Emergency Contact:<br>(If different from Next of Kin) | Name:..... Contact No:.....<br>Relationship to you:.....(eg: Mother) | | |

☐ **YES, I WOULD LIKE TO REGISTER FOR PERSONALLY CONTROLLED ELECTRONIC HEALTH RECORDS** - Please discuss process with reception.

NARANGBA VALLEY MEDICAL CENTRE

# CONFIDENTIAL MEDICAL HISTORY QUESTIONAIRE

Full Name: ..... DOB: .....

Do you have any Allergies? Yes/No Allergy Details: .....

Do you smoke? Yes/No/ Ex-Smoker Duration: .....

No. per day: ..... Date ceased: .....

Do you drink Alcohol? Yes/No, No. drinks per day: ..... No. days per week: .....

Are you currently taking any Medications or Alternative Medications (Herbs/Vitamins) Yes/No?

Please List: .....

Do you take recreational Drugs: Yes/No Please Specify.....

Do you have or have you ever had any of the following conditions?
(Please tick and specify details of diagnosis and treatment)

| Condition | Yes | No | Year Diagnosed | Details and Treatment Received |
|---|---|---|---|---|
| Arthritis | | | | |
| Anemia | | | | |
| Angina/Chest Pain | | | | |
| Asthma | | | | |
| Anxiety | | | | |
| Blood Pressure | | | | |
| Blood Disorders | | | | |
| Cancer | | | | |
| Diabetes | | | | |
| Depression or Mental Illness | | | | |
| Epilepsy | | | | |
| Heart Condition | | | | |
| Hepatitis | | | | |
| HIV/AIDS | | | | |
| Infectious Diseases | | | | |
| Stroke | | | | |

Please list any additional Medical Conditions not listed above: .....

.....

Are you aware of a family history of the above mentioned medical conditions: Yes/No?
Please specify: (e.g. Mother - Heart Conditions Father - Stroke)

.....

Have you had any operations: Yes/No?

Please Specify: .....

☐ I am aware that the information I have given is needed by the Doctors' Surgery in order to provide the safest possible medical care and that it is treated with the strictest confidence within the practice.

☐ I have answered all the questions honestly and am aware that I need to inform the Doctor of any changes at any subsequent visits.

Please discuss with your Doctor any medication you are taking, including herbal and alternative medicines.

Print Name: ..... Signature: .....Date: .....

NARANGBA VALLEY MEDICAL CENTRE

PATIENT CONSENT FORM

*Welcome to Narangba Valley Medical Centre*

To enable ongoing care and total quality improvement within this practice, and in keeping with the Privacy Act 1988 and National Privacy Principles, we wish to provide you with sufficient information on how your personal health information may be used or disclosed and record your consent or restrictions to this consent.

Your personal health 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 personal health 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 and Health Insurance 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 / guardian) are consenting, that on obtaining your personal health information it may be used or disclosed by the practice for the following purposes:

- Follow up reminder / recall notices for treatment and preventive health care,
- For accounting procedures and the collection of professional fees,
- The diagnosis and treatment of any health condition, including the communication of relevant information only, to practice staff, specialists and other healthcare providers to ensure quality care is provided,
- Accreditation and Quality Assurance activities are conducted by professionally trained non-treating GP's and other professionally trained and qualified persons e.g. General Practice Managers,
- For legal related disclosure as required by a court of law,
- For the purpose 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,
- For disease notification as required by law,
- 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.

**CONSENT**

I, _____ give my permission for my personal health information to be collected, used and disclosed as described above. I understand only my relevant personal health 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.

Patient Name (please print): _____

Signature: _____ Date: _____

If not Patient signing- Your Name (please print): _____

Your relationship (eg, Mother, Father, Guardian): _____