Churinga Medical Centre

465 Mount Dandenong Rd
Kilsyth 3137
Ph: 9722 9888
admin@churimed.com.au

New Patient Information Form

Title: Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master ☐ Other

Given Names: _____ Surname: _____

Date of Birth : ____/____/____ Gender at Birth: Male ☐ Female ☐

Gender Identity: Male ☐ Female ☐ Transgender ☐ Non-Binary ☐

Address _____

Postal Address: _____

Mobile Number: _____

Home Number: _____ Work Number: _____

Email Address:

Medicare Card Number: _____ Ref #____ Exp ____/____

Health Care Card Number: _____ Exp ____/____/____

Pension Card Number: _____ Exp ____/____/____

DVA Card Number: _____ Exp ____/____/____

Gold Card ☐

Next of Kin, Name: _____ Relationship to You: _____

Phone Number: _____

Emergency Contact (Or same as Next Of Kin) ☐

Name _____ Relationship to You: _____

Phone Number:

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

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

Yes, Torres Strait Islander ☐ Yes, both Aboriginal and Torres Strait Islander ☐

Country of Birth: _____ **Cultural Background (Ethnicity):** _____

Is English your first language? Yes ☐ No ☐ Do you require an interpreter? Yes ☐ No ☐

Language spoken at home if not English:

Staff Initial _____

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Medical History

Current Health Condition - *Please list any health conditions that you currently have & year of Diagnosis*

-
-
-

Current Medications - *Please list any medications that you currently take*

-
-
-

Allergies - *Please list any known allergies & the Reaction, including Food, Medications, Dressings*

-
-

Previous Operations Injuries or Hospitalisations *Including the Year*

-
-

Family History -

☐ Heart Disease ☐ Mental Illness ☐ Diabetes ☐ Stroke
☐ Asthma ☐ High Blood Pressure ☐ Cancer *(Type)* _____
☐ High: Cholesterol ☐ Other _____

Health Information and Lifestyle Risk Factor Information

Do you Smoke? No ☐ Yes ☐ How many per day _____ ☐ Ex Smoker - Year Quit _____

Do you Vape? No ☐ Yes ☐

Do you drink Alcohol? No ☐ Yes ☐ How many Drinks per Day ____ Week _____Month _____

Do you take Recreational Drugs? No ☐ Yes ☐ Type_____ Frequency _____

Date of last Cervical Screen _____ Breast Check _____

Last overall health check-up _____ Occupation _____

Living Arrangements? With Family ☐ Alone ☐ With other _____

Marital Status ☐ Single ☐ Married ☐ De Facto ☐ Divorced ☐ Widowed

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

Staff Initial _____

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Patient Consent

This general practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose and treat illnesses and medical conditions, ensuring we are proactive in your health care. To enable ongoing care, and in keeping with the Privacy Act 1988 and Australian Privacy Principles, we wish to provide you with sufficient information on how your personal information may be used or disclosed and record your consent or restrictions to this consent. Your personal 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 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 details, data collected from observations and conversations with you, and details obtained from other health care providers (eg. Specialist correspondence). By signing below, you (as a patient/parent/guardian) are consenting to the collection of your personal information, any that it may be used or disclosed by the practice for the following purposes.

- Administration purposes in running our general practice.
- Billing purposes, including compliance with Medicare & Health Insurance Commission requirements.
- Disclosure to others involved in your health care, including doctors and specialist outside this medical practice this may occur through referral, or for medical tests included reports or results returned to us following the referrals.
- Accreditation and quality assurance activities to improve individual and community health care and practice management.
- For legal related disclosure as required by a court of law.
- For the purposes of research only where de-identified information is used.
  To allow medical students, doctors, locums, allied health & staff to participate in medical training/teaching using only de-identified information.
- To comply with any legislative or regulatory requirements eg. Notifiable diseases.
- For use when seeking treatment by other doctors, locums, allied health & staff in the 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. Please complete the form below if you understand and agree to the following statements in relation to our use, collection, privacy and disclosure of your patient information. I have read the information above and understand the reasons why my information is to be used or disclosed. I understand that if my information is to be used for any purpose other than that set out above, my further consent will be obtained. I give my permission for my personal information to be collected, used and disclosed as described above (including electronic communication, primarily SMS to my mobile where applicable. May also include email, secure messaging or facsimile. I understand only my relevant personal 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's Name: _____ Date: _____

Patient's Signature: _____

Signed as Guardian/Caregiver/Parent: _____

Your relationship to patient eg. Mother, father, daughter, guardian: _____

ADMIN USE ONLY

Information entered by

Staff Member_____

Date _____

Consultation with Nurse Yes ☐ Or

No ☐ Reason_____

Nurse on Duty _____

Staff Initial _____