



# New Patient Information Form

## Mandurah Doctors

We are committed to providing our patients with the best care. To do this it is essential that your medical records are up to date and accurate.

Please assist us by completing the following:

Surname	Mr/Mrs/Miss/Ms/Master		
First Name			
Date of Birth:	Gender:		
Marital Status:	Single / Married / Divorced / De facto / Widowed		
Street Address			
Suburb and Post Code			
Home Phone			
Work Phone			
Mobile Phone			
Email Address			
Country of Birth			
Occupation			
Medicare Number	Ref No	Expiry Date	
DVA Gold / White (Please circle)		Expiry Date	
Pension Number		Expiry Date	
Health Care Card		Expiry Date	
Private Health Cover			
Next of Kin	Name:		
Relationship	Partner, Husband, Wife, Son, Daughter, Mother, Father, Guardian, Brother, Sister, Friend		
Contact No	Phone:		
Emergency Contact	Name:		
Relationship	Partner, Husband, Wife, Son, Daughter, Mother, Father, Guardian, Brother, Sister, Friend		
Contact No	Phone:		

Do you need an interpreter? Yes No Please Circle

If yes, what language do you speak? \_\_\_\_\_

### 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. If you do not want this reminder service, please let us know.

Please circle No Yes

Recalls and reminders  I consent to  SMS  Letter notification

Email (i.e. recalls/reminders) to be sent to me.

To assist with health initiatives - Are you of Aboriginal or Torres Strait Islander origin?

Yes  No Aboriginal  Torres Strait Islander

I consent to my health summary being uploaded to My Health Record by my Healthcare Provider.

Would you like escripts  paper scripts



# New Patient Information Form Mandurah Doctors



## Welcome – Privacy Policy

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:

- You consent to any doctor in the practice accessing your clinical records.
- Follow up reminder/recall notices for treatment and preventive healthcare.
- 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 eg. General Practice Managers.
- 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 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.
- To be placed on national registers (e.g. immunisation data) or state and territory based systems (e.g. cervical screening - pap smears or familial cancer registries).

**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.**

---

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 to patient (e.g. Mother, Father, Guardian)

\_\_\_\_\_



# New Patient Information Form Mandurah Doctors

**I have read the Practice Information Brochure and I agree to the terms and conditions of being a patient here.**

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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

Yes (If yes please list below)  No

**Please Describe Reactions:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Your Health History - Do you have or had a history of?**

Operations

\_\_Type\_\_\_\_\_

Asthma

\_\_\_\_\_

Diabetes

\_\_\_\_\_

Hypertension

\_\_\_\_\_

Chronic illness

\_\_\_\_\_

Other

\_\_\_\_\_

**Social History**

Tobacco: \_\_\_\_\_ day / week or Ceased Smoking - date \_\_\_\_\_ or Non Smoker

Alcohol: \_\_\_\_\_ day / week / month (circle the one applicable)

Drug use: \_\_\_\_\_ (type and frequency)

**Height:** \_\_\_\_\_ cms / ft

**Weight:** \_\_\_\_\_ kgs

**Blood Pressure: When was the last time your blood pressure was taken?**

\_\_\_\_\_



# New Patient Information Form Mandurah Doctors



**Current Medications (including over the counter medications, vitamins and minerals)**

---

---

---

---

---

---

## Family History - Has any members of your family had?

Diabetes

Asthma

Heart Disease

Mental illness

Cancer

## Immunisations - Have you had the following immunisations?

Tetanus booster	date_____	<input type="checkbox"/> Don't Know	<input type="checkbox"/> Haven't had one
Hepatitis B	date_____	<input type="checkbox"/> Don't Know	<input type="checkbox"/> Haven't had one
Hepatitis A	date_____	<input type="checkbox"/> Don't Know	<input type="checkbox"/> Haven't had one
Influenza	date_____	<input type="checkbox"/> Don't Know	<input type="checkbox"/> Haven't had one
Pneumococcal	date_____	<input type="checkbox"/> Don't Know	<input type="checkbox"/> Haven't had one
Polio	date_____	<input type="checkbox"/> Don't Know	<input type="checkbox"/> Haven't had one

## Children's Immunisations - If completing this form for a child is their immunisations up to date?

Yes       No

## For those 65 years and older: When was the last time you were immunised?

Influenza	Date_____	<input type="checkbox"/> not sure	<input type="checkbox"/> never
Pneumococcal pneumonia	Date_____	<input type="checkbox"/> not sure	<input type="checkbox"/> never

## Females: When did you last have?

Pap smear	Date_____	<input type="checkbox"/> not sure	<input type="checkbox"/> never
Breast Check	Date_____	<input type="checkbox"/> not sure	<input type="checkbox"/> never

## Males: When did you last have?

An overall check-up      Date \_\_\_\_\_       not sure       never