New Patient Information Form (adult)

Welcome to Riverstone Family Medical Practice. It will be helpful if we can obtain as much information as possible about you. This information will be made available to the health practitioners in the Practice and relevant information may be shared with health professionals outside the Practice who have direct involvement in your medical care. The information will not be given to anyone without your permission.

Title:	Dr ❑ Mr ❑ Master ❑ Mrs ❑ Ms ❑ Miss ❑ Other:		
First Name:		Date of Birth:	
Middle Name:		Phone Home:	
Last Name:		Mobile:	
Preferred Name:		Work:	
Email:		Proof of ID:	
Address:			
Suburb:		Post Code:	
Sex:	Male ❑ Female ❑ Other ❑		

If the practice needs to contact you and leave a message, we may use your:

Home: Yes ❑ No ❑	***Mobile:*** Yes ❑ No ❑	***Work:*** Yes ❑ No ❑	***Email:*** Yes ❑ No ❑

Next of Kin:

Name:		Relationship:	
Phone Home:		Mobile:	

Second Contact Person (for emergencies)

Name:		Relationship:	
Phone Home:		Mobile:	

Names and ages of family members at home:

What is your main ethnic background?	
What language(s) are spoken at home?	
Interpreter Needed?	Yes ❑ No ❑
Are you of Aboriginal origin?	Yes ❑ No ❑
Are you of Torres Strait Islander origin?	Yes ❑ No ❑

Are you entitled to any of the following concessions?

Health Care Card	Number:	Expiry:	Ref#:
Pension	Number:	Expiry:	Ref#:
DVA Gold/White	Number:	Expiry:	Ref#:
Medicare	Number:	Expiry:	Ref#:

How did you hear about our practice? ……

Cancellation Policy: If you are unable to attend your scheduled appointment, we would appreciate your early cancellation with at least 2 hours' notice. *A fee of $20 applies to any appointment not cancelled with at least 2 hours' notice* or if the appointment is missed. Patients who cancel 3 or more consecutive appointments even with sufficient notice will incur an additional $20 fee. No refunds will be provided for cancelled appointments and is not claimable with Medicare or private health funds. We appreciate your understanding as we want to work with all our patients to provide the best care possible and failure to attend your scheduled appointment is hindering this goal. Please acknowledge that you have read and understand this important policy …… ❑

Patient's Name: ……

Please complete the following by ticking in the box with the correct answer.

Have you suffered from?			Comments
High Blood Pressure	Yes ❑	No ❑	
Diabetes	Yes ❑	No ❑	
Heart disease including heart attack or angina	Yes ❑	No ❑	
Lung disease including asthma	Yes ❑	No ❑	
Stomach or bowel problems	Yes ❑	No ❑	
Kidney disease	Yes ❑	No ❑	
High Cholesterol	Yes ❑	No ❑	
Thyroid disease	Yes ❑	No ❑	
Brain disease, stroke or head injury	Yes ❑	No ❑	
Mental illness including depression or anxiety	Yes ❑	No ❑	
Cancer of <u>any</u> kind including skin cancer	Yes ❑	No ❑	
Abnormal Pap smear (females only)	Yes ❑	No ❑	
Prostate abnormalities (males only)	Yes ❑	No ❑	
Skin disease including Eczema and Psoriasis	Yes ❑	No ❑	
Migraine or frequent headaches	Yes ❑	No ❑	
Joint disease including arthritis and back pain	Yes ❑	No ❑	
Have you had any operations?	Yes ❑	No ❑	
Have you ever smoked?	Yes ❑	No ❑	
Do you ever take alcohol?	Yes ❑	No ❑	
Do you exercise regularly?	Yes ❑	No ❑	
Do you take any regular medication?	Yes ❑	No ❑	
Do you take vitamins, supplements or herbal therapies?	Yes ❑	No ❑	

Other illnesses ……

Do you have any allergies, including dressings? *Please list:* ……

……

Has anyone in your family (parents, brothers, sisters or children) suffered from any of the following illnesses?

High blood pressure	Unsure ❑	Yes ❑	No ❑	
Diabetes	Unsure ❑	Yes ❑	No ❑	
Heart disease	Unsure ❑	Yes ❑	No ❑	
High cholesterol	Unsure ❑	Yes ❑	No ❑	
Breast Cancer	Unsure ❑	Yes ❑	No ❑	
Thyroid disease	Unsure ❑	Yes ❑	No ❑	
Bowel cancer	Unsure ❑	Yes ❑	No ❑	
Other illnesses	Unsure ❑	Yes ❑	No ❑	

Thank you for your assistance. If you have any questions please feel free to ask.

RIVERSTONE FAMILY MEDICAL PRACTICE
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Privacy & Consent

In line with the provisions of the Commonwealth Privacy Act (1988) and the National Privacy Principles, you are asked to give your consent to Riverstone Family Medical Practice for the collection and storage of your personal and health information. The information you provide will form part of your medical record and be stored in our computer system.

It is necessary for us to collect personal information from our patients (and sometimes others associated with their health care) in order to look after their health needs and for associated administrative purposes.

No access to your health or other personal information, in any form, will be provided to any unauthorized person or to any person or organization outside of this practice without your permission.

1. I consent to Riverstone Family Medical Practice recording and storing the information I have provided on this form. I understand that this information will form part of a computerized database. Yes ❑ No ❑

2. I give my consent to Riverstone Family Medical Practice using the information I have provided to issue reminders and recalls to me and to send practice information by SMS, phone, email or letter. I understand that a third-party service may be used. Yes ❑ No ❑

3. In the event that I need to be referred for further tests and/or investigations or to a specialist or other health professional, I give my consent to my doctor disclosing essential personal and health information for that purpose. Yes ❑ No ❑

4. I have read and understood the written information given to me titled Privacy Policy, including the issues around electronic communication with the Practice. Yes ❑ No ❑

Patient Name: _____ **(Parent/Guardian)** _____

Signature: _____ **Print Name:** _____

Date: _____ **Staff Witness:** _____