HUB MEDICAL CENTRE

Lifelong Family Healthcare

NEW PATIENT FORM

Patient Details

Title: (please tick)	☐ Mr ☐ Mrs ☐ Ms ☐ Mast ☐ Miss	
Surname:	Given Name:	
Middle Name:	Preferred Name:	
Date of Birth: / /	Sex: ☐ Male ☐ Female	
Ethnicity:	Occupation: ☐ Retired (please tick)	
Residential Address:	Suburb:	Postcode:
Postal Address: ☐ As above (please tick)	Suburb:	Postcode:
Home:	Work:	Mobile:
Do you consent for SMS reminders: ☐ Yes ☐ No		
Do you consent for electronic communication: ☐ Yes ☐ No		
Email:		
Do you identify as: (please tick) ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither		

Medicare & Concession Card Information

Medicare Card No: __ __ __ __   __ __ __ __ __   __   Ref No: __   Expiry __ __/__ __ __ __

☐ Pension / ☐ Health Care Card No:__ __ __   __ __ __   __ __ __ __ Expiry __ __/__ __/__ __ __ __
(please tick)

DVA Card No: __ __ __ __   __ __ __ __ __ DVA Condition: ☐ Gold / ☐ White (please tick)

Next of Kin Details

Name:			
Address:		Suburb:	Postcode:
Home:	Work:	Mobile:	
Relationship to Patient:			

Emergency Contact Details

Name: ☐ As above (please tick)			
Address:		Suburb:	Postcode:
Home:	Work:	Mobile:	
Relationship to Patient:			

Personal Medical Information

Allergies (if none, please write "nil known")

____

____

____

Significant Illnesses / Medical Problems (please include approximate year)

____

____

____

Previous Operations (please include approximate year)

____

____

____

Family History (please include all known significant problems / illnesses)

Father:____

Mother:____

Brothers & Sisters: ____

Grandparents:____

Smoking History	Drinking History
Please Tick □ Current smoker What year did you start? ________ □ Ex smoker □ Never smoked Do you smoke? □ Daily, on average how many daily? ________ □ Less then weekly □ Weekly	Please Tick □ Everyday, on average how many daily? ________ □ 1-2 days per week □ 1-2 days per month □ Less than monthly □ Never When do you have six or more drinks on one occassion? □ Daily or almost daily □ Weekly □ Less than monthy □ Monthly □ Never

How did you find out about us?

□ Family/ Friend □ Close to Home/ Work □ Website □ Online booking service □ Other

Privacy Information

At this practice, we collect personal information from our patients for the primary purpose of providing quality health care services. 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.

To ensure the security of personal information held in this practice, all records are stored on computer, are password protected and are only accessible by authorised staff (all of whom have signed confidentiality agreements) within the practice. This practice will only use Medicare numbers collected from patients for the purpose of billing for medical services provided. The information you provide will only be for:-

- The primary purpose of providing quality health care services
- Administrative purposes for our medical practice
- Billing purposes, including compliance with Medical Australia requirements
- Disclosure to others involved in your health care, including treating doctors, specialists and medical technicians outside of this practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us
- Disclosure to other doctors within this practice, locum, for the purpose of patient care
- Disclosure for research and quality assurance activities (using only de-identified data) to improve individual and community health care and practice management.
- Disclosure to State and Commonwealth Reminder Systems Pap Smear Register, Immunisation Register for preventative health care

In other situations we would not disclose your personal information without obtaining your consent.

We will endeavour to ensure that all personal information collected is accurate, complete and correct.

Patients who wish to access their personal health information are welcome to discuss these matters with their treating doctors. Should access be denied, a reason for this denial will be provided to you. Should you require a copy of your personal information an administration fee may be incurred.

I have read and understood the information above and understand the reasons why my information must be collected.

I am also aware that this practice has a privacy policy on handling patient information.

I understand that if my information is to be used for any purpose other than set out above, my further consent will be obtained.

I therefore consent to the handling of my information by this practice for the purpose set out above, subject to any limitations on access or disclosure that I notify this practice of.

FEMALE PATIENTS

I agree to participate in State and Commonwealth Reminder Systems Pap Smear Register, Immunisation Register for preventative health care: Please tick: □ I agree □ I do not agree

Patient/Guardian Signature: Date: / /