PYMBLE MEDICAL & DENTAL CENTRE
NEW PATIENT INFORMATION FORM

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

PLEASE USE BLOCK LETTERS AND WRITE CLEARLY – THANKYOU.

Could you please assist us by completing the following:

Title	Mr	Mrs	Ms	Miss	Dr
Surname			Date of Birth		
Given Name			Preferred Name		
Street Address					
Suburb & Postcode					
Home Phone		Work Phone		Mobile Phone	
Email				Tick to opt out of SMS appointment reminders	
Medicare Number			Position on card	Expiry Date	
DVA Gold / White (please circle)				Expiry Date	
Pension Number				Expiry Date	
Comm. Snrs Health Care Card #					
Health Care Card #				Expiry Date	
Private Health Fund					
Next of Kin	(Name, relationship and telephone number of the person we can contact if needed)				
Emergency Contact	(Name, relationship and telephone number of the person we can contact if needed)				

If we need to contact you what is your preferred method of contact:

☐ Home phone ☐ Work phone ☐ Mobile phone

Do you have any health concerns on which you would like to receive more information?

____

Australia is a genuinely multicultural society. To tailor appropriate care, encourage understanding and appreciation between people from different nationalities and backgrounds.

Do you identify as someone from a culturally and/or linguistic diverse background?

☐ Yes – Please elaborate ____________________

☐ Do you need a translator?

To assist with health initiatives please tell us about your background.

☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal & Torres Strait Islander Heritage ____________________

Your health history: Do you have or have you had a history of?

☐	Operations	☐	Hypertension
☐	Asthma	☐	Chronic illness
☐	Diabetes	☐	Other

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

☐ Yes (please specify)____ ☐ No

Please continue over the page

MEDICAL

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Immunisations – Have you had the following immunisations?

Tetanus booster	date ____________________	☐ Don't Know	☐ Haven't had one
Hepatitis B	date ____________________	☐ Don't Know	☐ Haven't had one
Hepatitis A	date ____________________	☐ Don't Know	☐ Haven't had one
Influenza	date ____________________	☐ Don't Know	☐ Haven't had one
Pneumococcal	date ____________________	☐ Don't Know	☐ Haven't had one
Polio	date ____________________	☐ Don't Know	☐ Haven't had one
Zostavax	date ____________________	☐ Don't Know	☐ Haven't had one

Current medications (including over the counter medications, vitamins and minerals)/or other health supplements.

____

____

Previous Doctor: Name and Address: ____

Family History: Have any members of your family had?

☐ Diabetes ☐ Mental Illness ☐ Heart Disease

☐ Asthma ☐ Cancer

Social History:

☐ Tobacco _____day/week or ceased smoking - date

☐ Drug use – type and frequency.

____

☐ Alcohol Standard drinks _____/day or ____/week or _____/month

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

Sun Protection: How often do you use the following to protect yourself from the sun when outdoors?

	Always	Often	Sometimes	Rarely	Never
Protective clothing					
Protective creams					

Females: When did you last have?

Pap Smear Date Not sure / never

Breast Check Date Not sure / never

Males: When did you last have?

An overall checkup Date Not sure / never

How did you hear about us?

☐ Website ☐ Walk/Drive By ☐ Letterbox Flyer ☐ Family/Friends ☐ Other __________________

My Health Records

I have received information regarding *My Health Record* and I consent to be registered for *My Health Record*. ☐

Your Privacy & Medical Information

This medical 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 full medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. This means that we will use the information for administrative purposes, billing, disclosure to others involved in your health care; including specialists and other treating doctors outside the practice and disclosure to other doctors in the practice including locums to assist in your medical care. The practice may occasionally be involved in research and quality assurance activities to improve individual and community health and practice management. We wish to assure you that at all times your health information is treated with utmost confidentiality.

I have read and understood the above information regarding my medical information and am aware I can request a full copy of the privacy and collection statement.

____/____/____

Signature of patient (or guardian if *under 16*) Date

PLEASE PROVIDE PHOTO ID TO ACCOMPANY THIS REGISTRATION FORM IF YOU ARE OVER 18.

Head of Family details if patient is <u>under 17</u>

Name ______________________________

Medicare No. _________________________ Ref. ____

D.O.B. / /

MEDICAL

PYMBLE
Medical & Dental
CENTRE
THORNLEIGH
Medical Centre

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You have consented to register for EHealth.

To create a *My Health Record,* information about you and your children is collected from Medicare and some other government bodies including your name, date of birth and Medicare records from the last two years.

Registered healthcare providers such as this practice as well as hospitals will be able to access your *My Health Record* when providing healthcare to you. You can set access controls to restrict which healthcare providers can see your health information.

NAME ________________________________ DATE OF BIRTH _________________________

Patient consent:

Consent to upload healthcare information by healthcare provider organisations	☐ Yes	☐ No
Consent to load future MBS information into *My Health Record*	☐ Yes	☐ No
Consent to load past MBS information into *My Health Record*	☐ Yes	☐ No
Consent to load future PBS information into *My Health Record*	☐ Yes	☐ No
Consent to load past PBS information into *My Health Record*	☐ Yes	☐ No
Consent to upload Australian Organ Donor Register details into *My Health Record*	☐ Yes	☐ No
Consent to upload Aust Childhood Immunisation Register details into *My Health Record*	☐ Yes	☐ No

Signed: ___________________________ Dated: ____________________________