MEDICAL ON MARY

14 Mary Street, Gympie, QLD 4570 Tel (07) 53914067

NEW PATIENT INFORMATION FORM

Mr/Master/Mrs/Ms/Miss	Surname	
First name	Middle Name Preferred Name	
*DATE OF BIRTH		
*RESIDENTIAL ADDRESS/	Suburb	State
*POSTAL ADDRESS	Post Code	
Contact Number Mobile Home		
Emergency Contact Number	Name Relationship	
EMAIL		
Medicare card Number	IRN	Expiry date: day/month / year
Concession card # (HCC / PCC /) Please circle	Expiry Date day / month / year	
DVA Card Number Gold /White /Non specific. Please encircle	Expiry date: Month/Year	

DO YOU REQUIRE AN INTERPRETER Yes No

TO ASSIST WITH HEALTH INITIATIVES:

Do you identify as an Aboriginal? Yes No

Do you have a North Coast Card? Yes / No Membership Number:_____

Do you identify as a Torres Strait Islander? Yes No

Do you currently have private health insurance? Yes No

Name of Provider_____ Membership Number_____

REMINDER SYSTEMS:

We have a reminder system and provides our patients with preventive care and early case detection reminders, e.g. immunisations, annual health checks, skin checks and pap smears.

Do you wish to have health reminders sent to you? Yes / No Would you like an SMS appointment reminder? Yes / No

Your Health History

PAST MEDICAL HISTORY FOR EXAMPLE Medical/SURGICAL PROCEDURES, MEDICAL CONDITIONS

_____

_____

ALLERGIES Yes / No

_____

Do you give permission for Medical on Mary to upload your My Health Record Yes / No

FAMILY HISTORY

Who is in the family has/had any of the medical conditions below? (Please list family members name)

Diabetes_____Asthma_____HeartDisease_____Mental Illness_____Cancer

Others_____

Social History

Tobacco:_____day / week or Ceased Smoking –date___/____/___

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

Drug use_____ (type and frequency)

Height: _____ cms Weight: _____ kgs

When was your last Skin Check (skin cancer)? Date _____ not sure never

When was your last Bowel Screen? Date _____ not sure never

IMMUNISATIONS - HAVE YOU HAD THE FOLLOWING IMMUNISATIONS? (PLEASE LIST)

Tetanus booster 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

Shingles Date_____ Don't Know Haven't had one

FEMALES:

When did you last have? (Please List)

Pap smear Date_____ not sure never Mammogram Date_____ not sure never

PATIENTS SIGNATURE OR PARENT / GUARDIAN (IF CHILD IS A MINOR)

_____ Date ____/___/____

PRIVACY PATIENT INFORMATION

To provide a high standard of medical care we need to collect personal information from our patients. This information is usually collected from the patient but may be collected from family members and other health care provider's with the patient's consent. At times some of this information needs to be shared with other health care providers or we may be legally bound to disclose personal information. All persons accessing your personal health information are bound by confidentiality. Please do not hesitate to discuss any concerns, questions or complaints about any issues related to the privacy of your personal information with your Doctor. If you require another member of your family to access your medical results of tests, this cannot be done without a consent form signed by the patient. Please ask our reception staff for this form if you require one.

PRIVACY ACT

PATIENT CONSENT TO COLLECT & DISCLOSE INFORMATION

The Privacy Act 1988 requires medical practitioners to obtain consent from their patients to collect, use and disclose that patient's personal information.

This means we will collect information that is necessary to properly advise and treat you. Such information may include: full medical history; Medicare / private health fund detail, family medical history; genetic information; and ethnicity; billing / account details Clinical images (photographs) contact details;

The information will normally be collected directly from you. There may be occasions when we will need to obtain information from other sources, for example: other medical practitioners, such as former Hospitals and Day Surgery Units GPs and specialists; other health care providers, such as physiotherapists, psychologists, pharmacists, dentists, nurses; Both our practice staff and the medical practitioners may participate in the collection of this information. In emergency situations we may need to collect personal information from relatives or other sources where we are unable to obtain your prior express consent.

Use & Disclosure

With your consent, the practice staff will use and disclose your information for purposes such as: account keeping and billing purposes; referral to another medical practitioner or health care provider; sending of specimens, such as blood samples or pap smears, for analysis; referral to a hospital for treatment and / or advice; advice on treatment options; the management of our practice; quality assurance, practice accreditation and complaint handling; to meet our obligations of notification to our medical defence organisations or insurers to prevent or lessen a serious threat to an individual's life, health or safety; and where legally required to do so, such as producing records to court, mandatory reporting of child abuse or the notification of diagnosis of certain communicable diseases to make available your records to the on-call doctor, for your medical treatment, when the need arises. to supply results / reports / recommendations to your referring doctor pertaining to your medical management.Conflict of Interest Information

We provide the following information on potential conflicts of interest. A conflict of interest exists when a person entrusted with the interests of a patient, other individuals or the public violates that trust by promoting their own interests or the interests of third parties. Conflicts of interest may be financial, professional, personal, ethical, moral or religious. A conflict of interest exists when such interests compromise known obligations and interfere with objective professional judgment. Doctors must resolve such conflicts in accordance with the best interests of the patient. Our doctors have relationships with numerous hospitals, pharmaceutical, medical device and service provision companies who rely on their expertise. Occasionally they serve on advisory boards, provide expert opinion and perform research for companies and institutions.

Access

You are entitled to access your own health records at any time convenient to both yourself and the practice.

Access can be denied where: to provide access would be a serious threat to your life or health; there is a legal impediment to access; the access would unreasonably impact on the privacy of another; your request is considered frivolous; the information relates to anticipated or actual legal proceedings and you would be entitled to access the information in those proceedings; andIn the interests of national security.

Consent

I provide my consent for Medical on Mary to collect, use and disclose my personal information as outlined above. I provide consent for referrals and results to be sent to a medical specialist or doctor by facsimile.

I provide consent for messages to be left with immediate family members / de-facto partner (e.g. appointment confirmation). I understand that I am entitled to access my own health records except where access would be denied as outlined above.

I understand that I may withdraw my consent as to use and disclosure of my personal information (except when legal obligations must be met).

Print Name: _____

Signed by Patient:

X _____