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| **Richlands Medical Centre****Shop 8, Richlands Plaza, 511 Archerfield Rd, Richlands QLD, 4077**P: (07) 3879 6230 | F: (07) 3879 2016  | **Dr Edward Kwok** MBBS (QLD), FRACGP, DCH (Sydney)**Dr Angela Bowman** MBBS (QLD), FRACGP**Dr Loreta Blanco** MD, FRACGP**Dr Leo Schneider-Fensky** FRACGP**Dr Farron Young** MBBS (QLD), FRACGP |

**NEW PATIENT FORM**

­­We are committed to providing our patients with the best care. To do this, it is essential that your health record contains complete and accurate information. Please assist us by completing your new patient record form.

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| GENERAL INFORMATION |
| Title: | D.O.B.\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_ | Known as: |
| First name: | Middle name: |
| Surname: |
| Marital status: 🞏 Single 🞏 Married 🞏 Widowed 🞏 Divorced 🞏 Defacto 🞏 Separated |
| Street Address: | Suburb: |
| Post code: |
| Postal Address OR 🞏 As above | Suburb: |
| Post code: |
| Home: | Work: | Mobile: |
| Email:  | Occupation: |
| EMERGENCY CONTACT DETAILS |
| Name: | Relationship to you: |
| Home:  | Mobile: |
| NEXT OF KIN |
| Name: | Relationship to you: |
| Home:  | Mobile: |
| HEALTHCARE IDENTIFIERS |
| Medicare number:  | Reference: | Exp: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ |
| Dept. of Veterans’ Affairs file number:  | 🞏 All 🞏 Specified |
| Concession card number:  | Exp: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ | 🞏 Pension 🞏 Health Care |
| CULTURAL IDENTITY |
| To assist with health initiatives - are you Aboriginal and/or Torres Strait Islander?🞏 No 🞏 Yes – Aboriginal 🞏 Yes - Torres Strait Islander 🞏 Yes - Aboriginal and Torres Strait Islander |
| Ethnicity: | Do you require an interpreter service? 🞏No 🞏 Yes |
| Country of birth: | Year of arrival in Australia: | Language: |
|  YOUR HEALTH INFORMATION |
| ALLERGY INFORMATION - Do you have any allergies or are you sensitive to drugs or dressings? 🞏 No 🞏 Yes – provide details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| CURRENT MEDICATIONS – Please list all your current medications, including complementary and over-the-counter medicines (e.g. homeopathic medicines such as vitamins and minerals etc.)·\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ·\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_·\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ·\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_·\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ·\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **MEDICAL HISTORY** - Do you have or have you had a history of the following?🞏 Asthma 🞏 Hypertension 🞏 Surgery – provide details:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_🞏Diabetes 🞏 Chronic Illness 🞏 Other – provide details:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **LIFESTYLE RISK FACTOR INFORMATION** |
| **SMOKING** | **ALCOHOL** |
| 🞏 Smoker 🞏 Ex-smoker 🞏 Never smoked (Skip to “ALCOHOL”)  | How often do you have a drink containing alcohol?🞏 Never (Skip to “RECREATIONAL DRUG USE”) 🞏 Monthly or less 🞏 2 – 4/month 🞏 2 – 3/week 🞏 4+/week  |
| Frequency: 🞏 Daily 🞏 Weekly 🞏 Less than weekly  |
| No. of cigarettes: | Year started: | How many standards drinks containing alcohol do you have/day?🞏 1- 2 🞏 3 – 4 🞏 5 – 6 🞏 7 – 9 🞏 10+ |
|  Are you interested in quitting?🞏 Not currently thinking of quitting🞏Thinking of quitting in the next 6 months)🞏Planning to quit in 1 month)🞏Quit within the last year | How often do you have 6+ drinks on one occasion?🞏 Never 🞏 Less than monthly 🞏 Monthly 🞏 Weekly  🞏 Daily/almost daily  |
| Are you concerned about your drinking? 🞏 Yes 🞏 No 🞏 Don’t know  |
| Last quit attempt: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞏 Never/unknown | RECREATIONAL DRUG USE🞏 No 🞏 Yes – type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Frequency: \_\_\_\_\_\_\_\_\_\_\_\_ |
| Duration of longest period of abstinence: |
| **FAMILY HEALTH HISTORY INFORMATION** |
| Have/do any of your family members had/have:🞏 Heart Disease 🞏 Asthma 🞏 Diabetes 🞏 Hypertension (high blood pressure) 🞏 Mental Illness 🞏 Cancer – type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞏 Other significant – provided details:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Please turn over and complete the health information collection and use consent form. Once complete, please return to reception.**

**HEALTH INFORMATION COLLECTION AND USE CONSENT**

This general 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 a full medical history so that we may properly assess, diagnose and treat illnesses and medical conditions, ensuring we are proactive in your health care. To enable ongoing care, and in keeping with the *Privacy Act 1988* and *Australian Privacy Principles*, we wish to provide you with sufficient information on how your personal information may be used or disclosed and record your consent or restrictions to this consent.

Your personal 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 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 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 are consenting to the collection of your personal information, and that it may be used or disclosed by the practice for the following purposes:

* **Administrative purposes** in the operation of our general practice including contacting you via phone, text or post.
* **Billing purposes**, including compliance with Medicare requirements.
* **Follow-up reminder/recall** notices for treatment and preventative healthcare, frequently issued by **text message,** **phone call or mail**.
* **Disclosure to others involved in your health care**, including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals.
* **Accreditation and quality assurance activities** to improve individual and community health care and practice management.
* 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**
* To comply with any **legislative or regulatory requirements**, e.g. notifiable diseases.
* For use when seeking **treatment by other doctors** in this practice.
* For **online appointments, appointment reminders, recalls and preventative health reminders** through HotDoc. For terms of service, feel free to go to https://www.hotdoc.com.au/practices/terms-of-service-patients/.

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.

**PLEASE NOTE THAT:**

* The doctors at this practice have the right to **discontinue care at their discretion.**
* If 3 or more appointments are missed without suitable reason/notice (at least 2 hours) in a 6 month period (or less) a **cancellation fee** may apply and the doctor may choose to **discontinue care.**
* Any **inappropriate behaviour** which jeopardizes the safety and/or security of patients, staff or visitors may result in **prohibition from the practice**.
* If there is concern that there is a **risk of threatened safety**, staff may **knock on the door, call through** to the doctor or **enter the room** during your consultation.

**By signing this document, I acknowledge that I;**

* **Have read the information above and understand the reasons why my information must be collected.**
* **Am not obliged to provide any information requested of me, but failure to do so may compromise the quality of health care and treatment given to me**
* **Am aware of my rights to access the information collected about me, except in some circumstances where access may be legitimately withheld (I will be given an explanation in these circumstances).**
* **Understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.**
* **Consent to the handling of my information by the practice for the purpose set out above, subject to any limitations on access or disclosure of which I notify this practice.**

 Patients Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient’s signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_\_\_\_\_\_\_\_