NEW PATIENT RECORD 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:

# PATIENT DETAILS

Title: …….. Family Name: ……………………………………..……………… First Name: ……………………………………………

Preferred Name: ……………………………………………. Date of Birth: ……/…………/…………. Gender: ……………….

Are you Aboriginal or Torres Strait Islander? Yes / No Are you Australian? Yes / No

Country of Birth: ………………………………………………….………. Ethnicity: ………………………………………………………

Address: ……………..……………………………………………………………………………………………………….…………………………

Suburb: ……………………………………………………………………………………….………. Post Code: ………………..……….

Mobile Phone: ……………………………………………………… Home Phone: ……………………………..……………………….

Email: ………………………………………………………………………………………………………………………………………….………….

Medicare Number: ………………………………………………………………………………

Ref No. on Card: …… Expiry Date on Card: …………………………………

Please select if you have any of the below:

* Pensioner Concession Card ☐ Health Care Card
* Commonwealth Seniors Health Card ☐ Dept of Veterans Affairs

No. and Expiry: ……………………………………………………………………………….………….

Private Health Fund (Please select):

* NIB ☐ BUPA ☐ MEDIBANK ☐ ahm OHSC ☐ Other (please state). ………………………………..

Number:……………………………………………………..

Next of Kin Name: …………………………………………………… Relationship to patient:……………………….............

Mobile Phone: …………………………………………….……….. Home Phone ………………………………………………….…

Emergency Contact (if different to above) : ……………………………………………………………………………………….

Mobile Phone: …………………………………………….. Home Landline Phone:. ………………………………………………

What is your occupation: …………………………………….………………………………

Do you consent to Camberwell Medical Group sending SMS reminders: Yes / No

How did you find out about us? ☐ Google ☐ Social Media ☐ HOTDOC ☐ Health Engine ☐ DocBook

* Former patient ☐ Walking past clinic ☐ Word of Mouth ☐ Other (please state)………………………………

# HEALTH INFORMATION

ALLERGY INFORMATION-

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

* No
* Yes - provide details: …………………………………………………………………………………………………………………….….…

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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LIFESTYLE RISK FACTOR INFORMATION-

Do you have or have you had a history of the following? Smoking

☐ No ☐ Ceased – date:……………………….. ☐ Yes - how many........day/.........week / month

Alcohol

☐ No ☐ Ceased – date:……………………….. ☐ Yes - how many........day/.........week / month

Please sign this form as confirmation that you have read and understood our Privacy Policy **on the next page**, and consent to the use of your health information in this way.

Print Full Name: ……………………………………………………………………………………………………………………………………..

Patient Signature: …………………………………………………………………………………………………………………………………..

Date: ……/…………/………….



# PATIENT CONSENT

In keeping with the Privacy Act of 2001, we require your written consent as follows:

Our Practice respects your right to privacy. We realize that it is important that you understand the purpose for which we collect details about your health, as well as how this information is used at our practice and to whom this information may be disclosed.

* 1. The information collected will be used for the purpose of providing treatment to you. Personal information such as your name, address and contact numbers will be used for the purpose of addressing mail to you, utilizing our recall system and SMS reminders.
  2. We may disclose your health information to other health care professionals, or require it from them if, in our judgement, that is necessary in the context of your treatment. In that event, disclosure of your personal details will be minimized wherever possible. When shared, this will be shared via our fax.
  3. We may also use parts of your de-identified health information for research purposes, in study groups or at seminars as this may provide a benefit to other patients.
  4. Your medical history and any other material relevant to your treatment will be kept here. You may request copies of our records of your treatment or seek an explanation from the doctor.
  5. If any of the information we have about you is inaccurate, you may ask us to alter our records accordingly.

You can be assured that your health information will be treated with the utmost confidentiality. Disclosure will not be made to any person not involved in either your treatment or the administration of this practice, without your prior consent. A copy of our Privacy Policy is available at Reception.

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