WYNLOREL GENERAL PRACTICE 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.

Could you please assist us by completing the following:		
Title	☐ Dr ☐ Mr ☐ Mrs ☐ Ms ☐ Miss	
Surname		
First Name		
Date of Birth		
Street Address		
Suburb and Post Code		
Home Phone		
Work Phone		
Mobile Phone		
Email		
Medicare Number & Ref	#:	Expiry:
☐ **DVA Gold** ☐ **DVA White** (Please tick which)	#:	Expiry:
Pension Number	#:	Expiry:
Health Care Card Number	#:	Expiry:
Private Health Cover	Name:	#:
Next of Kin / Relationship to you (Name and Telephone number)		
Emergency Contact (Name and Telephone number of the person we can contact if needed)		
Employer Name		
Employer Address		
Employer telephone no.		

Reminder Systems

Our practice provides our patients with preventive care and early case detection reminders e.g. immunisations, annual health checks, repeat screenings, (blood tests, x-rays, scans) skin checks and pap smears.

Do you wish to have any relevant health reminders sent to you?	
☐ Yes – by Mail ☐ Yes - by SMS	☐ No
If we need to contact you what is your preferred method of contact:	
☐ Home Phone ☐ Mobile	☐ Mail
Are there any health concerns that you would like to receive information on?	

Patient Background

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?
☐ No ☐ Yes. Please elaborate:
To assist with health initiatives – are you an Aboriginal or Torres Strait Islander?
☐ No ☐ Yes - Aboriginal ☐ Yes - Torres Strait Islander ☐ Yes – Aboriginal & Torres Strait Islander

Your Health History

Do you have or have you had a history of the following? (please elaborate)
☐ Operations
☐ Asthma
☐ Diabetes
☐ Hypertension
☐ Chronic Illness
☐ Other
Do you have any allergies or are you sensitive to drugs or dressings?
☐ No ☐ Yes. Please elaborate:

Immunisations

Have you had the following immunisations? (list date where appropriate)			
Tetanus Booster	☐ Yes. Date:	☐ No	☐ Don't Know
Hepatitis B	☐ Yes. Date:	☐ No	☐ Don't Know
Hepatitis A	☐ Yes. Date:	☐ No	☐ Don't Know
Influenza	☐ Yes. Date:	☐ No	☐ Don't Know
Pneumococcal	☐ Yes. Date:	☐ No	☐ Don't Know
Polio	☐ Yes. Date:	☐ No	☐ Don't Know

Children's Immunisations

If completing this form for a child are their immunisations up to date?
☐ Yes ☐ No

Current Medications

Please list all current medications including over the counter medications, vitamins and minerals:

Family History

Have any members of your family had: (please elaborate)
☐ Heart Disease
☐ Asthma
☐ Diabetes
☐ Mental Illness
☐ Cancer

Social History

Do you use any of the following: (list amount where appropriate)	
Tobacco	☐ No. ☐ Yes. Number ____ day / ____ week **or** ☐ Ceased smoking
Alcohol	☐ No. ☐ Yes. Number ____ day / ____ week / ____ month
Drug Use	☐ No. ☐ Yes. Type _____ / Frequency _____

Measurements

Height	_____ cm
Weight	_____ kg

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?					
Protective clothing	☐ Always	☐ Often	☐ Sometimes	☐ Rarely	☐ Never
Sunscreen creams	☐ Always	☐ Often	☐ Sometimes	☐ Rarely	☐ Never

For those 65 years and older:

When was the last time you were immunised?			
Influenza	Date:	☐ Not sure	☐ Never
Pneumococcal pneumonia	Date:	☐ Not sure	☐ Never

Females

When did you last have?			
Pap Smear	Date:	☐ Not sure	☐ Never
Breast Check	Date:	☐ Not sure	☐ Never

Males

When did you last have?			
Overall Checkup	Date:	☐ Not sure	☐ Never

HEALTH INFORMATION COLLECTION, USE & DISCLOSURE - PATIENT CONSENT FORM

Dear Patient,

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. Your personal information will only be used for the purposes for which it was collected or as otherwise permitted by law. The information we collect may be collected by a number of different methods, and may include, but not limited to: 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).

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. This includes the following purposes:

- Administrative purposes in the operation of our general practice.
- Billing purposes, including compliance with Medicare requirements.
- Follow-up reminder/recall notices for treatment and preventative healthcare, frequently issued by SMS.
- 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 using only de-identified information.
- To comply with any legislative or regulatory requirements, e.g. notifiable diseases.
- For use when seeking treatment by other doctors in this practice.

Please complete the form below if you understand and agree to the following statements in relation to our use, collection, privacy and disclosure of your patient information.

Consent:

I, _____ have read the information above and understand the reasons why my information must be collected, and the purposes for which my information may be used or disclosed. I understand that if my information is to be used for any purpose other than that set out above, my further consent will be obtained.

I, _____ give permission for my personal information to be collected, used and disclosed as described above, including contact via SMS to my mobile phone number. I understand that only my relevant personal information will be provided to allow the above actions to be undertaken and I am free to withdraw, alter or restrict my consent at any time by notifying this practice in writing.

Patient/guardian name: (please print) _____

Signature: _____ Date: _____

Witnessed by: (staff signature) _____