New Patient Information Form
Lakelands Doctors

We are committed to providing our patients with the best care. To do this it is essential that your medical records are up to date and accurate.
Please assist us by completing the following:

Surname	**Mr/Mrs/Miss/Ms/Master**		
First Name			
Date of Birth:	**Gender:**		
Marital Status:	**Single / Married / Divorced / De facto / Widowed**		
Street Address			
Suburb and Post Code			
Home Phone			
Work Phone			
Mobile Phone			
Email Address			
Country of Birth			
Occupation			
Medicare Number	**Ref**	**Expiry Date**	
DVA Gold / White (Please circle)		**Expiry Date**	
Pension Number		**Expiry Date**	
Health Care Card		**Expiry Date**	
Private Health Cover			
Next of Kin **Relationship** **Contact No**	**Name:** **Partner, Husband, Wife, Son, Daughter, Mother, Father, Guardian, Brother, Sister, Friend** **Phone:**		
Emergency Contact **Relationship** **Contact No**	**Name:** **Partner, Husband, Wife, Son, Daughter, Mother, Father, Guardian, Brother, Sister, Friend** **Phone:**		

Do you need an interpreter? Yes No Please Circle
If yes, what language do you speak? _____
Reminder Systems:
Our practice provides our patients with preventive care and early case detection reminders, e.g. immunisations, annual health checks, skin checks and pap smears. If you do not want this reminder service, please let us know.
Please circle No Yes
Recalls and reminders □ I consent to □ SMS □ Letter notification
□ Email (i.e. recalls/reminders) to be sent to me.
To assist with health initiatives - Are you of Aboriginal or Torres Strait Islander origin?
☐ Yes ☐No Aboriginal ☐ Torres Strait Islander ☐
□ I consent to my health summary being uploaded to My Health Record by my Healthcare Provider.

Would you like escript □ paper script □

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Welcome – Privacy Policy

To enable ongoing care and total quality improvement within this practice, and in keeping with the Privacy Act 1988 and National Privacy Principles, we wish to provide you with sufficient information on how your personal health information may be used or disclosed and record your consent or restrictions to this consent.

Your personal health 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 personal health 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 and health insurance 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 (as a patient/guardian) are consenting, that on obtaining your personal health information it may be used or disclosed by the practice for the following purposes:

- You consent to any doctor in the practice accessing your clinical records.
- Follow up reminder/recall notices for treatment and preventive healthcare.
- For accounting procedures and the collection of professional fees.
- The diagnosis and treatment of any health condition, including the communication of relevant information only, to practice staff, specialists and other healthcare providers to ensure quality care is provided.
- Accreditation and Quality Assurance activities are conducted by professionally trained non-treating GP's and other professionally trained and qualified persons eg. General Practice Managers.
- 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.
- For disease notification as required by law.
- For use when seeking treatment by other doctors in this practice.
- To be placed on national registers (e.g. immunisation data) or state and territory based systems (e.g. cervical screening - pap smears or familial cancer registries).

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.

I, _____ give my permission for my personal health information to be collected, used and disclosed as described above. I understand only my relevant personal health 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 Name: (Please Print) _____

Signature: _____ Date: _____

If not patient signing -Your name (Please Print) _____

Your relationship to patient (e.g. Mother, Father, Guardian)

_____

I have read the Practice Information Brochure and I agree to the terms and conditions of being a patient here.

Name: _____

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Accredited General Practice

Signature: _____

Date: _____

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

☐ Yes (If yes please list below) ☐No

_____

Please Describe Reactions: _____ ___

_____

_____

_____

_____

Your Health History - Do you have or had a history of?

☐ Operations
__Type_____

☐ Asthma

_____

☐ Diabetes

_____

☐ Hypertension

_____

☐ Chronic illness

_____

☐ Other

_____

Social History

☐ Tobacco: _____ day / week or Ceased Smoking - date _____or Non Smoker □
☐ Alcohol: _____ day / week / month (circle the one applicable)
☐ Drug use: _____ (type and frequency)

Height: _____ cms / ft **Weight:** _____ kgs

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

_____

Current Medications (including over the counter medications, vitamins and minerals)

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_____
_____
_____
_____
_____
_____

Family History - Has any members of your family had?

☐ Diabetes

☐ Asthma

_____

☐ Heart Disease

_____

☐ Mental illness

_____

☐ Cancer

_____

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

Children's Immunisations - If completing this form for a child is their immunisations up to date?

☐ Yes ☐ No

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?

An overall check-up	Date _____	☐ not sure	☐ never