TOORAK MEDICAL CENTRE

PATIENT INFORMATION 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 information form.

Contact Information	
Gender	Male Female Intersex Transgender Other
Title	
Surname	
First Name	
Second Name	
Known As	
Date of Birth	
Street Address	
Postal Address (if different to above)	
Home Phone	
Work Phone	
Mobile Phone	
Email	
Emergency Contact Details	
Name	
Relationship to you	
Home Phone	
Mobile Phone	
Next of Kin	
Name	
Relationship to you	
Home Phone	
Mobile Phone	
Healthcare Identifiers	
Medicare Number:	Ref Expiry /
Dept of Veteran Affairs Card Number	Gold White
Concession (Pension/Health Care) Care Number	Expiry /
Cultural Identity	

Do you identify as - Aboriginal and/or Torres Strait Islander?

No Yes – Aboriginal Yes – Torres Strait Islander Yes-Aboriginal and Torres Strait Islander

As someone from a culturally and/or linguistic diverse background do you require an Interpreter Service:
No Yes

Country of Birth: _____Year of Arrival: _____

Spoken/Preferred Language: _____

TOORAK MEDICAL CENTRE

Checking In

It is essential when arriving for your appointment that you check in and update your details.

- using the Kiosk located next to the Aqua Door
- checking in at the Reception Desk.

Reminder Systems

Our practice provides our patients with preventative care and early case detection reminders e.g: immunisations, annual health checks, skin checks and Cervical Screening (Pap Smears).

Do you wish to have any relevant health reminders sent to you?

Yes – Mail	A :
Yes – Email at this address	E :
Yes – SMS to the mobile number	M :
None of these	

If we need to contact you what is your preferred method of contact: (Please Tick)

Home Phone
Mobile Phone/SMS Message
Mail
Email

Patient Consent

Signature:

Date:

TOORAK MEDICAL CENTRE

Date:			
Name:			
Date of Birth:			
Your Health History			
Do you have or have you had a history of the following? (Please Elaborate)			
	Surgery – Provide Details Overleaf		
	Asthma		
	Diabetes		
	Hypertension		
	Chronic Illness		
	Other		
Do you have any allergies or are you sensitive to drugs or dressings?			
	No		
	Yes – Please Elaborate:		
Immunisations			
	Tetanus Booster	Date:	Don't Know
	Hepatitis B	Date:	Don't Know
	Hepatitis A	Date:	Don't Know
	Influenza	Date:	Don't Know
	Pneumococcal	Date:	Don't Know
	Polio	Date:	Don't Know
Children's Immunisations			
If completing this form for a child are their immunisations up to date?			
	Yes		
	No		
	I don't know		
Current Medications			
Please list all current medicals including over the counter medications, vitamins and minerals:			
Family History			
Have any members of your family had: (please elaborate)			
	Heart Disease		
	Asthma		
	Diabetes		
	Hypertension		
	Mental Illness		
	Cancer		
	Other significant: Provide details:		

TOORAK MEDICAL CENTRE

Social History

Tobacco

No

Yes: Started_____ Stopped_____Duration_____

Number _____ day/ _____ week

Ceased Smoking:

When:_____

Alcohol

No

Yes: How many standard drinks _____ day _____ week _____ month

How often do you have 6 or more standard drinks on one occasion: (please tick)
Daily Weekly Monthly

Recreational 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:	Unsure	Never
Pneumococcal Pneumonia	Date:	Unsure	Never

Females

When did you last have?

Cervical Screening (Pap Smear)	Date:	Unsure	Never
Breast Check	Date:	Unsure	Never

Males

When did you last have?

Overall Checkup	Date:	Unsure	Never
Prostate Test	Date:	Unsure	Never

All

Bowel Cancer	Date:	Unsure	Never
Skin Check	Date:	Unsure	Never

Patient Consent:

Date:

TOORAK MEDICAL CENTRE

Please read this consent form carefully prior to signing.

This 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 illness and medical conditions, ensuring we are proactive in your health car. 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 (as a patient/parent/guardian) 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.
- 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.

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 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.

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 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.

If I am between the ages of 14-18 years I give my parents consent to access information regarding my health Yes No

Patient Name: (please print)_____

Signature:_____Date:_____

If not patient signing – your name (please print)_____

Signature:_____Date:_____

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

PRACTICE USE ONLY:

Witnessed by : (Staff Signature)_____