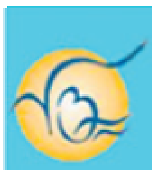
KINGS ROAD MEDICAL CENTRE



NEW PATIENT INFORMATION FORM

We need this information to provide the best quality care. This form complies with the RACGP *Standards for general practices*. This means your personal health information is kept private and secure, as required by federal and state privacy laws. If you have any concerns, please leave blank and discuss with your GP.

Please notify us promptly of any changes in your contact details. Accurate contact details help us identify you and your medical records, and allow us to contact you promptly about tests and results

SECTION A: PERSONAL DETAILS

Title	**Surname**	**Given Names**
Date of Birth (dd/mm/yyyy)		**Gender:**
Medicare number	**Reference no.**	**Card expiry date**
Concession card (e.g. Pension/HCC/Vet Affairs)	Type of Vet affairs card	Expiry date
Health insurance Yes ☐ No ☐ Name of fund:	Membership Number	Date (if joined <12months ago)
Defence Force members only – Service number	Rank	
Residential address		Post Code
Postal address		Post code
Contact number (Home)	(Work)	(Mobile)
Email address		
Occupation	Marital status	

NEXT OF KIN	EMERGENCY CONTACT
Name	Name
Relationship to Patient	Relationship to Patient
Address	Address
Phone Number	Phone Number

Do you have an advance health directive? Yes ☐ No ☐

SECTION B: CULTURAL BACKGROUND

Knowing your cultural background can help us provide healthcare that meets your individual needs.

Are you of Aboriginal or Torres Strait Islander origin?			
No ☐	Aboriginal ☐	Torres Strait Islander ☐	Aboriginal and Torres Strait Islander ☐

Other cultural background (e.g. Mediterranean, Asian, African, Indian)			Country of Birth		
Is English your first language?	Yes ☐	No ☐	If no, do you require an interpreter?	Yes ☐	No ☐
Please specify language					

Section C: Allergies and Medicines (if running late, skip this section)

List allergies and intolerances to medications	Describe your reaction
List regular medications, doses, and complementary medicines doses	

Section D: Consent:

We require your consent to collect personal information about you. Please read this information carefully and sign where indicated below.

This medical practice collects information from you for the purpose of providing equality in health care. In the course of the consultation, your doctor may ask you personal details and a full medical history so we may properly access, diagnose, treat and be proactive in your health care needs. This means we may use the information you provide in the following ways:

- Administrative purposes in running our medical practice
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements
- Disclosure to others involved in your healthcare, including treating Doctors and Specialists outside the medical practice. This may occur through referral to other Doctors, for medical tests, in the reports, or results returned to us following the referrals
- Disclosure to other Doctors in the practice, Locums, Registrars, or Medical students attached to the practice for the purpose of patient care and teaching. Please let us know if you do not want your records assessed for these purposes, and we will note this on your record accordingly.
- Disclosure to a medical legal defense organisation if a medico-legal issue arises
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I have read the information above and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling patient information

I understand that I am not obliged to provide information requested of me, but my failure to do so may compromise the quality of health care and treatment given to me.

I am aware of my right to access information collected about me, except in some circumstances where access might be legitimately withheld. I understand that I will be given an explanation in those circumstances.

I understand that if my information is to be used for any other purposes other than those set out above, subject to any limitations, access, or disclosure, that I notify the practice.

I understand that if I fail to attend any booked appointment without contacting the practice, I may be charged a cancellation fee. This will be required to be paid at the time of the next consultation.

Signed: _________________________________ Date: ____/_____/_____

Patient's Name: __________________________ DOB: ____/_____/_____