Hamilton Medical Centre
New 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 record form:

Contact Information	
Title:	
Surname:	
First Name:	
Date of Birth:	
Birth Sex:	☐ Male ☐ Female ☐ Other ☐ Unknown
Gender Identity:	☐ Male ☐ Female ☐Non-binary ☐Gender diverse ☐Transgender ☐Different identity ☐ Prefer not to say
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:	

Does anyone make decisions on your behalf?

☐ No ☐ Yes, please indicate which:

☐ Power of Attorney ☐ Enduring Guardianship ☐ Public Guardian ☐ Other _____

Do you have a carer? ☐ No ☐ Yes, please provide name and contact details:

Do you have an Advanced Care Directive in Place? ☐ No ☐ Yes, please provide a copy for our records

Healthcare Identifiers

Medicare Number: _____ Ref: _____ Expiry: ___/_____

Dept. of Veterans' Affairs File Number: _____ ☐ Gold ☐ White

Concession (Pension/Health Care) Card Number: _____ Expiry: ___/_____

Private Health Fund Name: _____ Member Number: _____

Cultural Identity

To assist with health initiatives - are you Aboriginal and/or Torres Strait Islander?

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

Ethnicity/Country of Birth: _____

Do you require an interpreter service? ☐ No ☐ Yes

How did you hear about us?

☐ Sign on street ☐ Friend or Family Referral ☐ Google ☐ HotDoc ☐ Facebook

☐ School ☐ Website ☐ Other: _____ *Thank you for your feedback*

Medical Information and History

Please circle if you have ever suffered from the following conditions:			
Heart Attack	Yes/No	Osteoporosis	Yes/No
Asthma	Yes/No	Angina or Coronary Heart Disease	Yes/No
Epilepsy	Yes/No	COPD or chronic Bronchitis or Emphysema	Yes/No
Heart Failure	Yes/No	Deep Vein Thrombosis (DVT) or Pulmonary Embolus (PE)	Yes/No
Diabetes	Yes/No	Irregular Heartbeat or Atrial Fibrillation (AF)	Yes/No
Thyroid problems	Yes/No	Stoke or Transient Ischaemic Attack (TIA)	Yes/No
Glaucoma	Yes/No	Mental Health Problems e.g. Depression	Yes/No
Cancer	Yes/No	Peripheral Vascular Disease (PVD or PAD)	Yes/No
High Blood Pressure	Yes/No	Kidney Problems	Yes/No
		Hepatitis	Yes/No

Please list any other serious illnesses OR operations and the date they started:			
Illness:		Start Date:	
Illness:		Start Date:	
Illness:		Start Date:	
Illness:		Start Date:	

Please list all medications you currently take including inhalers, injections, tablets, creams and eye drops:			
Medication:		Dose:	
Medication:		Dose:	
Medication:		Dose:	
Medication:		Dose:	

Are you allergic to anything that you know of e.g. medicines, metals, Elastoplast, latex?			
☐ No ☐ Yes, please list below:			
Allergy:		Reaction:	
Allergy:		Reaction:	
Allergy:		Reaction:	
Allergy:		Reaction:	

If there are any conditions that run in your family, please list them below:	
Condition:	
Condition:	
Condition:	

Smoking/Vaping and Alcohol
Have you ever smoked/vaped? ☐ No ☐ Yes Do you smoke/vape currently? ☐ No ☐ Yes, how many/much per day? _____
Do you drink alcohol? ☐ No ☐ Yes, how many standard units per day? _____

Women only:			
Are you pregnant now?	☐ No ☐ Yes	If yes, when is your due date?	
Have you ever had a pap smear?	☐ No ☐ Yes	If yes, what was the date of your most recent pap smear?	
Have you had a mammogram?	☐ No ☐ Yes	If yes, what was the date of your most recent mammogram?	

Patient Consent

Please read this consent form carefully prior to signing.

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. 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 and letters.
- 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.

HEALTH INFORMATION VIA EMAIL AND SMS - We encourage our patients to be proactive in their health care and to help with this we will from time to time send you information regarding any health initiatives from which we feel you may benefit. If you do not wish to receive this information, please advise the staff.

THIRD PARTY CONSENT – ADDITIONAL FORM REQUIRED (ATTACHED AT THE END OF THIS FORM)
Please complete a Consent Form - Authority to Act (3rd Party) to indicate if you wish to authorise or decline another person(s) to act on your behalf when communicating with the staff of Hamilton Medical Centre (HMC) regarding your care.

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. 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.

I, _____ will consent to the release of Pharmaceutical Dispense and Medicare Claim data should it be requested by the Doctors of this practice. I understand this information would be used only by the doctors and staff members of this practice to assist in providing me with appropriate and safe health care. I understand I may choose not to consent to release this information to the practice, however the practice reserves the right to request transfer of care elsewhere in this instance.

I consent to the following SMS options: (please tick if you consent, leave blank if not)

☐ Appointment Reminders ☐ Results/Clinical Messages ☐ Clinical Reminders ☐ Health Awareness

Patient name: (please print) _____

Signature: _____ Date: _____

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

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

PRACTICE USE ONLY:

Witnessed by (If applicable): (staff name) _____ (staff signature) _____

Has the patient fully completed the **Medical Information and History** questionnaire? ☐ Yes ☐ No _____

Has the **Consent Form - Authority to Act (3rd Party)** been completed & signed? ☐ Yes ☐ No _____

SMS consent options completed and uploaded: (staff signature) ☐ Yes ☐ No _____

Has the form been scanned and uploaded to BP? ☐ Yes ☐ No _____

Completed by: (staff name) _____ (staff signature) _____

Patient Consent Form – Authority to Act (Third Party)

Dear Patient,

This form can be used if you wish to authorise another person to act on your behalf when communicating with the staff of Hamilton Medical Centre (HMC) regarding your care. This applies to anyone aged 14 years and over.

I (Name) _____ Date of Birth: _____ of (Address) _____ hereby give authority for the following person(s), to act on my behalf, in the areas ticked or crossed below:

Person 1

Name: _____ Date of Birth: _____

Relationship: _____ Contact Number: _____

Authority to: ☐ Cancel Appointments ☐ Receive results

☐ Update contact details ☐ Pick up prescriptions/referrals/requests/forms

☐ Make or receive other calls, enquiries or correspondence, with any other HMC staff

Person 2

Name: _____ Date of Birth: _____

Relationship: _____ Contact Number: _____

Authority to: ☐ Cancel Appointments ☐ Receive results

☐ Update contact details ☐ Pick up prescriptions/referrals/requests/forms

☐ Make or receive other calls, enquiries or correspondence, with any other HMC staff

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

Consent

I, _____ have read the information above and understand that the information I have selected may be released or acted upon by my authorised person(s) as listed above. I understand that this authority can be withdrawn at any time either by verbal or written instruction.

Signature: _____ Date: _____

Decline Consent

I, _____ have read the information above and I ***do not*** give anyone permission to act on my behalf. I understand that this authority can be withdrawn at any time either by verbal or written instruction.

Signature: _____ Date: _____

PRACTICE USE ONLY:

Witnessed by (if applicable): (staff name) _____ (staff signature) _____

Entered onto BP: (Staff Name) _____ Date: _____