Chinchilla Medical Practice

NEW PATIENT REGISTER

Accredited General Practice

Title:_____ Surname:_____ First Name:_____

Middle Name:_____ Preferred Name:_____ Date of Birth:_____

Gender at Birth: Male/Female/Other_____ Identified Gender if different : _____

Residential Address: _____

_____Suburb: _____ P/Code: _____

Postal Address: _____

_____Suburb: _____ P/Code: _____

Home Phone: _____ Work Phone: _____ Mobile:_____

Email Address (personal):_____ @ _____

Ethnicity_____

Do you Identify as Aboriginal ☐ **Torres Strait Islander** ☐ **Neither** ☐ **Both?** ☐

If Aboriginal or Torres Strait Islander are you registered for CTG (Closing the Gap)? Yes ☐ **No** ☐

Medicare Card _____IRN_____Expiry Date_____

Concession Card type_____DVA Number _____Expiry Date_____

Private Health Fund_____Membership Number_____

How did you hear about Chinchilla Medical Practice? (please tick): Word of mouth ☐ Google ☐ Facebook Other ☐

Next of Kin (full name):_____

Address:_____ Suburb: _____

Relationship: _____ Phone:_____

Emergency Contact (full name):_____

Address:_____ Suburb: _____

Relationship: _____ Phone:_____

Reminder Systems: Chinchilla Medical Practice provides our patients with preventive health reminders e.g. immunisations, cervical screening tests and skin checks etc. We can provide these reminders via SMS, email or post. These reminders may remind you of future appointments and allow you to confirm your appointment. They may also notify you about your clinical care at the practice, such as returned pathology results or clinical messages from the medical practitioner. The practice will also send clinical reminders, reminding you to contact the practice to arrange appointments for regular clinical check-ups, medical procedures, immunisations, specialist letters etc.

If you wish to opt-out of the reminder system, please let reception staff know.

I wish to receive health awareness communications (as described above) and I consent to the use of my personal information (including any health information) by this general practice to assess types of health awareness communication.

My preferred method of contact for all communications is:

Phone ☐ Letter ☐ SMS ☐ Email ☐ Telehealth ☐

Consent to upload My Health? Yes ☐ No ☐

Please present this form, your Medicare card, any concession card and a form of photo ID to reception or Email back to reception@chinmedi.com.au

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CONSENT FORM- GENERAL COLLECTION AND USE OF PERSONAL INFORMATION

Chinchilla Medical Practice has produced a Privacy Policy that outlines how we collect and use your personal information generally, specifically your personal medical information, and how you can access this information.

Our practice adheres to Australian Privacy Principles and to the 'RACGP Handbook for the Management of Health Information'.

Your personal medical information may be collected, used and disclosed for the following reasons.

- For use by Medical practitioners in this practice when consulting with you.
- For communicating relevant information with other treating doctors, specialists or allied health professionals, to help achieve better health outcomes for you.
- For follow-up, reminder and recall notices.
- For accounting, Medicare or Insurance purposes.
- Quality improvement activities such as accreditation.
- As required by law.
- For employment, Workcover, Rehabilitation purposes where you have attended for that purpose.
- De-identified database searches for Public Health Planning.

This consent form enables us to collect and use your information to provide comprehensive, coordinated and continuing whole person medical care.

We will require a separate specific signed authority from you to release medical information, or a copy of our records, about you to insurance companies, lawyers or another Medical Practice, unless we are required by law to release this information.

The people that have access to your medical information are:-

- The doctors at "Chinchilla Medical Practice".
- The nurses at "Chinchilla Medical Practice".
- The senior Administrative staff at 'Chinchilla Medical Practice".

Other people including the administration staff, have access to your general, demographic and financial information, and may be exposed at various times to some medical information about you in the general course of looking after your health outcomes.

We will at no time divulge any information except in the above scenarios. Any breaches of this policy will be considered serious misconduct.

If you have any questions in relation to this consent form or our privacy policy, please ask our practice manager or the Doctor that you are seeing.

Access to the personal information held by us, about you, can be requested of the practice manager, or to the treating practitioner.

Transfer of my Medical Records

In order to provide the best possible care, I agree to Chinchilla Medical Practice obtaining my records from my previous doctor. Transfer via Medical Objects is our preferred method.

Signature_____ Date_____/_____/_____

Previous Practice _____ Phone: _____ Fax: _____

Allergies ☐ Yes ☐ No

Details: _____

Family and Social history

☐ Unknown ☐ No significant Family History

Mother alive? ☐ Yes ☐ No _____ Age of death _____Cause of death

Father alive? ☐ Yes ☐ No _____ Age of death _____Cause of death

Significant Family history:

Mother	Diabetes	☐	Hypertension	☐	Heart Disease	☐	Stroke ☐
	Colon Cancer	☐	Depression	☐	Breast Cancer	☐	
Father	Diabetes	☐	Hypertension	☐	Heart Disease	☐	Stroke ☐
	Colon Cancer	☐	Depression	☐			

Other Family history

Other Comment

Social

Marital Status _____

Sexuality _____

Elite Athlete ☐ **Yes** ☐ **No**

Breast feeding ☐ **Yes** ☐ **No**

Advance Health Directive ☐ **Yes** ☐ **No**

Enduring Power of Attorney ☐ **Yes** ☐ **No**

Recreational Activities _____

Accommodation _____

Lives with _____

Has Carer _____

Do you feel safe at home? ☐ **Yes** ☐ **No**

Other social history _____

Occupation

Current Occupation _____

Retired ☐ **Yes** ☐ **No**

ADF Service ☐ **Yes** ☐ **No** **Which one** _____

Alcohol

Current Alcohol Intake ☐ **Non-Drinker**

Days per week _____ **Standard drinks per day** _____

Description _____

Past Alcohol intake

☐ **Nil** ☐ **Occasional** ☐ **Moderate** ☐ **Heavy**

Year started _____ **Year stopped** _____

Comment _____

_____

Cage Questions _____

Standard Drinks _____

Audit C _____

Current Smoking History

☐ **Non Smoker** ☐ **Ex Smoker** ☐ **Smoker**

Cigarettes **Cigarettes per day** _____ **Year started** _____

Recreational Drugs **Per day** _____ **Year started** _____

Past smoking history

Quantity per day ☐ **Unknown** ☐ **< 1** ☐ **1-9** ☐ **10-19** ☐ **20-39** ☐ **40 +**

Patient would like cessation advice/ support ☐ **Yes** ☐ **No**

☐ **Brief advice to stop smoking given** ☐ **Prescribed cessation medication**

☐ **Provided cessation behavioural support** ☐ **Referred to cessation support**

Last updated _____

Patients Name: _____

Signature_____ Date_____/_____/_____