

Mr / Master / Mrs / Ms / Miss (please circle) other \_\_\_\_\_ Date of Birth \_\_\_\_\_

First Name \_\_\_\_\_ Surname \_\_\_\_\_

Home Address \_\_\_\_\_  
\_\_\_\_\_ (suburb)

Home Ph \_\_\_\_\_ Work Ph \_\_\_\_\_ Mobile \_\_\_\_\_

Email Address \_\_\_\_\_

Country of Birth \_\_\_\_\_ Other cultural background \_\_\_\_\_

Is English Your First Language? Yes / No (please circle) If No please indicate language: \_\_\_\_\_

Aboriginal  Torres Strait Islander?

**Do you have Private Health Insurance? Yes / No** Name of fund \_\_\_\_\_

**Next of Kin**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Relationship \_\_\_\_\_ Ph \_\_\_\_\_

**Emergency Contact**

I authorise the following person to take messages regarding a recall, reminder or change of appointment:

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Relationship \_\_\_\_\_ Ph \_\_\_\_\_

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**Office Use Only**

received back by ..... checked after scanning by .....

entered by .....

Medicare Card # ..... Pens/HCC # .....

Ref # ..... Expiry Date: .....

Expiry Date: .....

## Practice information collection statement

Hampstead Health Family Practice requires your consent to collect personal information about you.

Hampstead Health Family 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, treat and be pro-active in your health care needs. This means we will use the information you provide in the following ways:

- Administrative purposes in running our medical practice;
- Billing purposes, including compliance with Medicare Australia;
- Disclosure to others involved in your health care, including treating doctors and specialists outside this practice. This may occur through referral to other doctors, or for medical tests and in the reports returned to us following the referrals
- Disclosure to other doctors including locums and to allied health workers and nurses who work in the practice
- Disclosure to visiting teachers and accreditation surveyors for the purposes of teaching and accreditation of the practice; and/or Disclosures for research and quality assurance activities to improve individual and community health care and practice management. This information will be de-identified.

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 any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to me. I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances. I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained. By completing the section below and providing a signature, I consent to the handling of my information by this practice for the purposes set out above, subject to any limitation on access or disclosure that I notify the practice of.

Patient name: \_\_\_\_\_

Patient signature: \_\_\_\_\_

Date: \_\_\_\_\_

*Please read this carefully before signing*

In keeping with our obligations under Privacy Act 1988 and Australian Privacy Principles and under State and Territory health records legislation, we wish to inform you of the purposes for which we may use your personal information and how we may use and disclose your personal information (including health information). Please refer to our privacy policy or privacy statement available on our website for more information generally on the management of personal information (including health information) by this general practice.

**As part of the provision of health care services to you we may send you the following types of communications:**

1. **Appointment reminders** – notifications to you to remind you of upcoming appointment dates with the practice as well as allowing you to confirm your appointment
2. **Clinical reminders** - notifications to you to remind you to contact the practice to arrange appointments for regular clinical check-ups, medical procedures, immunisations due
3. **Clinical communications** - communications to you about your clinical care at the practice such as returned pathology results or clinical messages from the medical practitioner
4. **Health awareness** – communications to you in relation to general health care information and health care services provided by this general practice including notification about changes to our clinic opening hours, and information about health care services provided by this general practice.

To the extent practicable, we will send you communications via your preferred contact method indicated below. However, you acknowledge that we may contact you using any of your contact details that you may provide to us from time to time as we consider appropriate.

### Acknowledgements and Consent

I acknowledge and agree that, in the course of providing health care services to me, the general practice may need to use my personal information as set out in this form.

My preferred contact method for all communications is:

Phone  Letter  SMS  App  (Not available as yet, expected late in 2019)

Email

I acknowledge that the practice will use contact details provided by me (as updated by me from time to time) to communicate with me. To the extent that the mobile number I have provided to this general practice is utilised by more than one patient, I understand and consent that all SMS and phone communications will be directed to that number.

Please complete and sign below if you understand and agree to the acknowledgements and consent set out above.

Patient Name: \_\_\_\_\_

Patient/Guardian name: \_\_\_\_\_  
(if patient is under 16)

Signature: \_\_\_\_\_

## PERSONAL HEALTH HISTORY

**NAME:** ..... **D.O.B:** .....

**MARITAL STATUS:**  Single  Married  Separated  Divorced  Widowed  De facto

**OCCUPATION:** .....

**Do you have a regular GP elsewhere? If so please provide details below:**

**Dr's name:** ..... **Surgery name and address:** .....

Do you have or have you had a history of the following? (please give dates and description)	
<input type="checkbox"/> Operations	
<input type="checkbox"/> Asthma	
<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Hypertension	
<input type="checkbox"/> Mental Illness	
<input type="checkbox"/> Chronic Illness	
<input type="checkbox"/> Other	

Do you have any ALLERGIES, or are you sensitive to drugs or dressings?	
<input type="checkbox"/> No <input type="checkbox"/> Yes	Allergy to: ..... Reaction type: .....

Do you use any of the following: (list amount where appropriate)	
<b>Tobacco</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes – How many cigarettes per day? ... <input type="checkbox"/> Ceased smoking <b>Date Ceased:</b> ....
<b>Alcohol</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes – How many days per week? ... How many alcoholic drinks at a time? .....
<b>Illicit Drugs</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes – Type? ..... Frequency of use? .....

**Female clients: When was your last Pap smear?**

More than 2 years ago? <input type="checkbox"/>	More than 4 years ago? <input type="checkbox"/>	<b>Result:</b> <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
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Current medications including over the counter medications, vitamins and minerals:
<i>Please list them here:</i>

Have any members of your family had any of the following :	
<b>Mother</b> <input type="checkbox"/> Still living <input type="checkbox"/> Deceased	<input type="checkbox"/> Heart Disease <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Mental Illness <input type="checkbox"/> Cancer – Type: ..... <input type="checkbox"/> Other: .....
<b>Father</b> <input type="checkbox"/> Still living <input type="checkbox"/> Deceased	<input type="checkbox"/> Heart Disease <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Mental Illness <input type="checkbox"/> Cancer – Type: ..... <input type="checkbox"/> Other: .....
<b>Brother/s</b>	<input type="checkbox"/> Heart Disease <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Mental Illness <input type="checkbox"/> Cancer – Type: ..... <input type="checkbox"/> Other: .....
<b>Sister/s</b>	<input type="checkbox"/> Heart Disease <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Mental Illness <input type="checkbox"/> Cancer – Type: ..... <input type="checkbox"/> Other: .....

**Doctor to complete the following**

<b>Height</b>	cm	<b>BMI</b>	
<b>Weight</b>	kg	<b>BP (sitting)</b>	/ mmHg