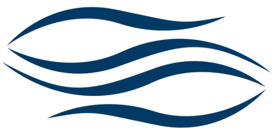
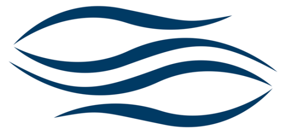


Barrier Reef Medical Centre

New Patient Information Form

It is essential that your health record is kept up to date
Please complete **ALL** of the form so we can provide the best care possible

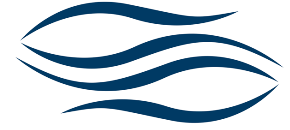


Title (Please Tick)	☐ Miss	☐ Ms	☐ Mrs	☐ Master	☐ Mr	☐ Dr
Gender	☐ Female		☐ Male		☐ Indeterminate	
First Name			**Middle Name**			
Surname			**Known As**			
Date of Birth	_ _ / _ _ / _ _ _ _					
Residential Address						
	Suburb		**Postcode**			
Postal Address (If Different)						
	Suburb		**Postcode**			
Contact Number	**Mobile**					
	Work		**Home**			
Email						
Medicare Card Number	_ _ _ _ _ _ _ _ _ _ Ref _ (number beside your name) Expiry Date _ _ / _ _ _ _					
If patient is 15 years or under, please complete the following →	**Legal Guardians Name**		**Date of Birth**			
	Is the Legal Guardian a patient at this practice?		☐ Yes	☐ No		
DVA Card Number		☐ Gold	☐ White (*Specify Condition/s*):			
Health Care/Pension Card		**Expiry Date**				
Next of Kin Contact		**Relationship**		**Ph**		
Emergency Contact		**Relationship**		**Ph**		
Ethnicity (Please Tick)	☐ Aboriginal	☐ Torres Strait Islander	☐ Neither			
Country of Birth		**Spoken Language**				
Occupation		**Employer**				

Your History	☐ Operations	☐ Asthma	☐ Diabetes	☐ Hypertension	☐ Chronic Illness	☐ Other
	Details:					
Family History	☐ Operations	☐ Asthma	☐ Diabetes	☐ Hypertension	☐ Chronic Illness	☐ Other
	Details:					
Allergies	**Do you have any known allergies and/or reactions?**	☐ Yes	☐ No			
	Please specify:					
Current Medications	*Please specify:*					
Social History	**Tobacco use**	☐ None	☐ Daily	☐ Weekly	☐ Socially	☐ Ex-Smoker
	Alcohol	☐ None	☐ Daily	☐ Weekly	☐ Socially	☐ Ex-Alcoholic
	Drug Use	☐ None	☐ Daily	☐ Weekly	☐ Socially	☐ Former User
Last Pap Smear	Date (*if known*):		**PLEASE TURN OVER →**			

Patient Consent Form

Australian Privacy Principles



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 running our general practice.
- Billing purposes, including compliance with Medicare requirements.
- Follow-up reminder/recall notices for treatment and preventative healthcare.
- 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.
- For the purpose of sending appointment reminders for scheduled appointments.
- 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.

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 my permission for my personal information to be collected, used and disclosed as described above (including contact via SMS to my mobile phone number as well as the use of my e-mail address when necessary).
- 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 you have any questions in relation to any of the above matters, please raise these with your doctor

Patient Name				
Photo ID	☐ Yes	☐ No	**Licence No:**	
Signature			**Date**	
If not Patient – Your Name				
Relationship to Patient **(e.g. Mother, Father, Guardian)**				

PRACTICE USE ONLY:

Witnessed by (Staff Signature): ________________________________ Date: ______________