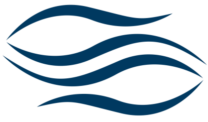
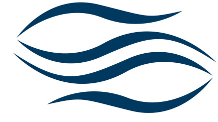


Barrier Reef Medical Centre

New Patient Information Form

Welcome to our medical centre.

Please ensure all details are completed to enable us to give you the best possible care



Patient Details

Title: *(please circle)* Mr Master Mrs Ms Miss Dr

Gender: *(please circle)* Male Female Intersex/Indeterminate Not Stated

First Name: Middle Name:

Surname: Date of Birth:

Preferred Name:

Marital Status: Single Married De Facto Widowed

Country of Birth: Aboriginal / Torres Strait Islander / Both *(please circle)*

Street No. & Name:

Suburb: Postcode:

Postal Address: *(if different)*

Suburb: Postcode:

Home Phone: Mobile:

Work Phone: Do you consent to SMS Reminders: Yes / No

Email Address:

Occupation: Employer:

Medicare & Concession Details

Medicare Card No: Reference:

Expiry:

Pension / Healthcare Card: Expiry:

DVA Card: Gold / White *(please circle)*

If patient is under 15 years of age Legal Guardians Name:

Date of Birth:

Is the legal guardian a patient of this practice? *(please circle)* Yes / No

Emergency Contact Details - Please complete 2 contacts

1. Emergency Contact Person:

Phone: Relationship:

2. Next of Kin Contact Person: *(different to your emergency contact)*

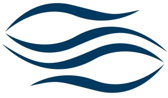
Phone: Relationship:

Acknowledgement

I accept it is my responsibility to inform the practice of any changes to my details.

Signed by Patient/Guardian: Date:

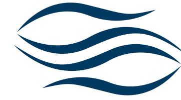
Please turn over page for patient consent, read through carefully and sign.



Barrier Reef Medical Centre

New Patient Medical History Form

Welcome to our medical centre.
Please ensure all details are completed to enable us to give you the best possible care



Patient Medical History - Infant to 15 Years

Name: ____________________	**DOB:** ____________
Birth Details	Preterm Full Term *(please circle)*
Family Details	Partent / Guardian Details: ____________ Name: ____________ Phone: ____________ Name: ____________ Phone: ____________ Family Medical History: ____________
Medical / Birth History	Please list any medical or birth history: ____________
Allergies	Item: ____________ Reaction: ____________
Medication	Please list any current medications *(including Vitamins and herbal medicine):* ____________
Immunisation	Up to date Not Immunised Unsure *(please circle)* **Location of immunisations:** Australia Overseas *(please circle)* If overseas, where?: ____________ **Extra Vaccinations:** ____________
Comments	Please list any comments: ____________

Parent / Gaurdian's Signature: ____________________ Date: ____________

We acknowledge that all the above information is confidential under the Privacy Amendment Act 2000 and this will be accessed by Medical Staff Only.

Barrier Reef Medical Centre

New Patient Medical History Form

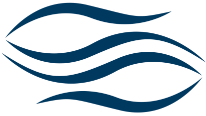
Welcome to our medical centre.
Please ensure all details are completed to enable us to give you the best possible care

Patient Medical History - 16 years to Adult

Name:		**DOB:**
Social History	**Live with:**	
	Extra Care at Home ***(eg Home help, Meals on Wheels):***	
	Marital Status: *(please circle)* Single Married Defacto Divorced Separated Widowed	
Smoking	Never Smoked Ex-Smoker Current Smoker *(please circle)*	
	Year Quit: Cigarettes per day:	
Alcohol	Never Monthly or less 2-4 times a month 2-3 times a week 4 or more times a week *(please circle)*	
	How many standard drinks on a typical day?:	
Family History	Please list any family medical history:	
Past Medical History	Please list any past medical / surgical history:	
Allergies	**Item:**	**Reaction:**
Medication	Please list current medications *(including vitamins and herbal medicine)* :	
Immunisations	Tetanus: *(year)*	Pneumococcal: *(year)*
	Hepatitis A/B: *(year)*	Shingles: *(year)*
	Influenza: *(year)*	Covid 19: Dose 1 Dose 2 *(please circle)*
Women's Health	Last Pap Smear/Cervical Screening Test: *(year)*	Normal/abnormal *(please circle)*
	Mammogram: *(year)*	
How did you hear about BRMC?		

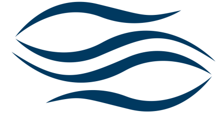
Patients Signature: ____________________ Date: ____________

We acknowledge that all the above information is confidential under the Privacy Amendment Act 2000 and this will be accessed by Medical Staff Only.



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.
- To upload to your personal “My Health Record” – a shared health summary and or an event summary.

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.

Consent for the collection and use of data as stated above ______________________

(Patient Signature)

If you have any questions in relation to any of the above matters, please raise these with The Practice Manager.

Patient Name:				
Photo ID: *(please circle)*	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: ______________