Welcome To Third Avenue Surgery: New Pt Form

Third Avenue Surgery is a Private Billing Practice

Name	Surname	First Name	(Mr / Mrs / Ms / Miss / Dr) (circle appropriate title)		
Birth Sex & Gender Identity	Birth Sex: Female/Male/other/unknown (circle appropriate birth sex)	Gender Identity: Male/Female/Non-binary/Gender diverse /Transgender/Different Identity (circle appropriate gender identity)			
Date of Birth / **Occupation**	Date of Birth	Occupation			
Address					
Suburb		**Postcode:**			
Contact Numbers	**Home:**	**Wk:**	**Mob:**		
SMS Reminders	I **do/do not** give permission for reminders/communication to be sent (please circle) **Please note: This is not to be used as your only reminder**				
Email Address	**Email Address:** _____ I **do/do not** give permission for reminders/communication to be sent via email (please circle)				
Next of Kin	**Name:**	**Contact Number:**	**Relationship to you:**		
Emergency Contact **This is compulsory:** & can be the same as Next of Kin	**Name:**	**Contact Number:**	**Relationship to you:**		
How did you hear about us?	**Word of Mouth**	**GP After Hours**	**Facebook**	**Website** / **Health Engine**	**Google** / **Drive By**
	Other:				

If you require any special consideration or assistance based on your cultural background please inform our staff when making your appointment.

☐ Yes – Please elaborate._____

To assist with Medical Assessment and Care: **please identify your Ethnicity.**
Ethnicity (national, cultural or racial origin)_____

To assist with Health Initiatives – Do you identify as ☐ Australian, non-Indigenous

☐ Aboriginal but not Torres Straight Islander ☐ Torres Strait Islander but not Aboriginal

☐ Both Aboriginal and Torres Strait Islander ☐ Prefer not to Answer

County of Birth ☐ Australia Other _____

Occupation _____

Do you require a Translator? _____ **Language Required for Translator**_____

Please be aware that failure to attend your scheduled appointments will incur a Missed Appointment Fee.
If you require your Medical records to be transferred from your previous GP please let us know.

Office Use Only **Entered by:**_____

Medicare No | | | | | | | | | | | ***Ref*** | | **Expiry Date** | |

HCC or Pension No (circle card type) | | | | | | | | | | | **Expiry Date** | |

DVA Gold / White (please circle) **Expiry Date**

PTO

Please sign the Health Information Collection and use Consent Form on the reverse side if this form to indicate your understanding of the information given. You will also be required to fill out a Medical Information Form prior to your first visit with the Dr

Health Information Collection and Use and Disclosure Patient Consent Form

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; we will 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 may include, but not limited to: 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, sent by post, and if consented, by SMS and/or email.
- 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.
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, including contact via SMS to my mobile phone number, and/or Email address. I understand that 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.

Patient name: (please print) _____Signature: _____Date: _____
If not patient signing - your name (please print)_____
Your relationship to patient (e.g. Mother, Father, guardian) _____

Please note: If you are seen at our After Hours Service, GP After Hours Mount Lawley, please be aware their terms and conditions vary from Third Avenue Surgery. A Practice Information Sheet is available in the Practice $ website: gpafterhoursmountlawley.com.au

New Patient Medical Information Form (completed form to be given to Dr)

Date: **Name:** **Date of Birth:**

BIRTH SEX: ☐ Male ☐ Female ☐ Other ☐ Unknown

GENDER IDENTITY:

☐ Male ☐ Female ☐ Non-binary ☐ Gender diverse ☐ Transgender ☐ Different identity

ALLERGY INFORMATION - Do you have any allergies or are you sensitive to drugs or dressings?

☐ No ☐ Yes – provide details:

CURRENT MEDICATIONS – Please list all your current medications, including complementary and over-the-counter medicines (e.g. homeopathic medicines such as vitamins and minerals etc.)

MEDICAL HISTORY - Do you have or have you had a history of the following?

☐ Surgery – provide details:

☐ Asthma

☐ Diabetes

☐ Hypertension

☐ Chronic Illness

☐ Other – provide details:

LIFESTYLE RISK FACTOR INFORMATION

Smoking

☐ Non smoker ☐ Ex smoker ☐ Smoker

Current Use: Cigarettes per day ____ Year started _____

Past Smoking History: Cigarettes per day ____ or Unknown

Year Started _____ Year Stopped _____

Alcohol

☐ Non Drinker ☐ Drinker

Days per Week ____ Standard drinks per day ____

Past Alcohol Intake: ☐ Nil ☐ Occasional ☐ Moderate ☐ Heavy

Recreational Drug Use

☐ No ☐ Yes - type_____ frequency _____

Family Health History Information

Do any members of your family have:

☐ Heart Disease

☐ Asthma

☐ Diabetes

☐ Hypertension (high blood pressure)

☐ Mental Illness

☐ Cancer – type:

☐ Other significant - provide details:

Date of last check up_____

If Applicable: Date of last Cervical Smear_____

Date of last Mammogram_____