Coffs Harbour GP Super Clinic

New Patient Information Sheet

Please fill out **ALL** of the form to ensure we can provide the best possible care available.

Title: ☐ Mr	☐ Mrs	☐ Dr	☐ Miss	☐ Ms	☐Single	☐Married	☐Partner
Surname:		**First Name:**			**Middle Name:**		
Date of Birth:							
Residential Address:							
Postal Address:							
Phone No: Home:			**Work:**		**Mobile:**		
E-mail Address:							
Medicare Card No:			Ref:		Expiry:		
Concession Card HCC/Pension/Seniors/DVA: No:					Expiry:		
Occupation:			**Employer**:				

Country of Birth:	**Primary Language:**	**Interpreter is required ☐Yes☐No**	
Do you **identify** as: ☐ Aboriginal	☐Torres Strait Islander	☐Both	☐ Neither
Cultural needs or Religious Beliefs:			

Next of Kin:	**Relationship:**	**Phone No:**
Emergency Contact ***(different from above)***:		**Relationship:**
Phone No:		

Legal Guardian (Children 15 years and under only):		☐ Next of Kin	☐ Emergency Contact
Is the **Legal Guardian** a patient at this Practice:		☐ Yes	☐ No
If **No** please give details:	Name:		DOB:
Medicare Card No:		Ref:	Expiry:

Signature:

Your health and family history – do you have or have you had a history of?
(Please include any family history as well)

Your History ☐ Operations ☐ Asthma ☐ Diabetes ☐ Hypertension ☐ Chronic Illness ☐ Other

Please give details_____

_____

Your Family History ☐ Operations ☐ Asthma ☐ Diabetes ☐ Hypertension ☐ Chronic Illness ☐ Other

Please give details_____

_____

Do you have any allergies or are you sensitive to drugs or dressings? Yes ☐ No ☐ ***(If Yes please list)***

Current Medications (including over the counter medications, vitamins and minerals):

Social History: ***(please circle)***

Tobacco use: _____ daily / weekly / irregular / ex-smoker - ceased - Date: _____

Alcohol: _____ type / amount / frequency

Drug use: _____ type / amount

Last Pap Smear Date: _____

Consent to Collect, Use and Disclose Personal Information

Welcome to Coffs Harbour GP Super Clinic

Coffs Harbour GP Super Clinic (CHGPSC) endeavours to uphold the Australian Privacy Principals in collecting, maintaining and storing personal medical information in a private and secure manner. As a patient of CHGPSC, we ask that you provide us with your personal details and health information so that we may properly assess, diagnose, treat and be proactive in your health care needs. 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.
- 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 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 all other avenues of contact have been exhausted). 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.

Patient Name: (Please Print) _____

Patient DOB: _____

Signature: _____ Date: _____

If not Patient signing - Your name (Please Print) _____

Your relationship to patient (e.g. Mother, Father, guardian)