NEW PATIENT INFORMATION

myallmedical PRACTICE

Title : Mr Mrs Ms Miss Master **Gender:** Male / Female

Given Name: _____ **Surname:** _____

Preferred Name: _____ **Date of Birth:** _____

Address: _____

Home Phone: _____ **Mobile:** _____

What Contact Number can Practice Staff call and leave a message on? _____

Are you happy to receive SMS Reminders for Appointments? Yes / No

Email Address: _____

_____

Emergency Contact Details: - Name of the Person You Would Like Practice Staff To Contact In An Emergency:

Name: _____ Home Phone: _____ Mobile No: _____ Relationship: _____

Next of Kin: _____ Home Phone: _____ Mobile No: _____ Relationship: _____

Address: _____

Cultural Diversity:

Were you born in Australia: **Yes / No** If no, in which country were you born: _____

Do you identify yourself as any of the following: (Tick all that apply) ☐ Aboriginal ☐ Torres Strait Islander ☐ South Sea Islander

Identification Details:

Medicare No: _____ Expiry: ___/___

DVA No: _____ Expiry: ___/___

Pension/Concess: _____ Expiry: ___/___

Drivers Licence: _____ Expiry: ___/___

Private Health Fund Details:

Do you have a Private Health Fund: Yes/No

Health Fund: _____ **Number:** _____

Due to confidentiality and privacy legislation, we are unable to give out information in regards to your personal medical records and investigation results without your consent.

Do you give permission for someone else to have access to your medical records? Yes / No
Name: _____

Do you have an enduring Power of Attorney? Yes / No
If so, who: _____

Do you give permission for someone else to access your investigation reports? Yes / No
Name: _____

Do you have an advanced health directive? Yes / No
Location: _____

I agree / do not agree to have my medical record reviewed by an AGPAL Surveyor if it is one of the records randomly chosen. I understand this is part of our Practice participating in the accreditation process for General Practice.

Agree ☐ **Do Not Agree ☐** **Signature:** _____ **Date:** _____

Please turn over to page 2

PLEASE COMPLETE SECOND PAGE AND HAND TO DOCTOR

Patient Name: ..... **DOB:**.....

Past History

Have you ever had:

Rheumatic Fever	☐	Diabetes	☐
TB	☐	Epilepsy	☐
Asthma	☐	Blood Pressure	☐
Stroke	☐	Heart Attack	☐
Thyroid Problems	☐	Clots in leg/lungs	☐

Have you ever had operations on:

Tonsils	☐	Appendix	☐
Gall Bladder	☐	Veins	☐
Hernia	☐	Joints/Bones	☐

Any treatment for mental health issues:

Depression ☐ Anxiety ☐ Other ☐

Family and Social History

Mother Alive Yes/No Age at Death:_____ Cause of Death _____

Father Alive Yes/No Age at Death:_____ Cause of Death_____

Other Significant Family History:

Mother:	Diabetes ☐		Colon Cancer ☐		Hypertension ☐	
Depression ☐	Heart Disease ☐		Breast Cancer ☐		Stroke ☐	
Father:	Diabetes ☐		Colon Cancer ☐		Hypertension ☐	
Depression ☐	Heart Disease ☐		Breast Cancer ☐		Stroke ☐	

Smoking: Non ☐ Ex ☐ Smoker ☐
Year Started _____ Year Finished _____ Number per day _____

Alcohol Intake: Days per week _____ Drinks per day _____

Occupation: _____

Any exposure to: Dust Asbestos Radiation Animals

Marital Status: _____

Breastfeeding: Yes/No **Elite Athlete**: Yes/No

Do you have any allergies or are you sensitive to any drugs or dressings: Yes/No
(If yes, pls list) _____

If completing this form for a child, are Immunisations up to date: Yes/No

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

_____

_____

myallmedical
PRACTICE

Date: .....

AUTHORISATION FOR 3RD PARTY DISCLOSURE

Due to documenting procedures for Accreditation and the National Privacy Principles we require you to complete this form: **AUTHORISATION FOR 3RD PARTY DISCLOSURE. Please print clearly, circle where appropriate and return to the surgery in the enclosed stamped addressed envelope supplied for your convenience.**

Patient Information:

Title:..... Given Name:..... Surname:.....

Date of Birth:.....

Telephone No. (Home) ..... (Work) .....

(Mobile) .....

Address:.....

.....

Postal (if different).....

Name of Next of Kin: ..... Relationship.....

Contact Telephone No.....

Mobile:.....

I authorise for the Doctors and support staff of Myall Medical Practice to speak with either my next of kin, or

(Nominated Authorised Person): ....., in the event that I am unable to be contacted, or unable to contact the rooms myself, for the purpose of managing appointments, prescriptions, or collecting X-ray or Pathology results.

I acknowledge that confidential information about my medical condition will not be passed on to the nominated person without my express authority. I also agree to the release of information to other medical practitioners or institutions that may be treating me, now or in the future, but only to the extent necessary to treat the particular condition for which I have consulted the Doctors at Myall Medical Practice.

Patient Signature:..... Date:.....