GREENSBOROUGH ROAD SURGERY

WATSONIA ROAD MEDICAL CENTRE

New Patient Details

Mr / Mrs / Miss / Ms / Master / Dr …… ……
(Given Names) (Surname)

DOB: ……/……/……. Address: ……

Suburb: …… Post Code: ……..

Ph (H): …….. Ph (B): …….. Mob: ……..

Email: ……

Occupation: ……

Do you identify as any of the following?

Aboriginal Yes / No Torres Strait Islander Yes / No Australian Yes / No

Do you identify yourself with any other nationality or culture? Yes / No

If yes, which culture……

Medicare No: …… Patient No: …….. Expiry Date: ……/……

Please circle:
Health Care Card / Blue Pension No: …… Expiry Date: ……/……/……

Veterans' Affairs No: …….. Gold / Other …… Expiry Date: ……/……/……

Person responsible for accounts: If same as above skip to next section.

Name: …… D.O.B: ……/……/…….

Address……

Medicare No: …… Patient No: …….. Expiry Date: ……/……

Next of Kin
Name: …… Relationship: ……

Ph (H): …….. Ph (B): …….. Mob: ……..

Emergency Contact:

Name: …… Relationship: ……

Ph (H): …….. Ph (B): …….. Mob: ……..

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Consent Form

To provide you with the highest quality health care service, Greensborough Road Surgery requires information about your medical history and other personal details. The information you provide us with is ultimately used so that we may properly assess, diagnose and treat you.

It is important for you to read through and understand this document. It details exactly how we use your personal information and who it is disclosed to. Once you sign this document, we have your consent to collect personal information about you for the purpose of providing medical services.

Greensborough Road Surgery will use your information for the following:

- Administration purposes in running our medical practice.
- Billing purposes, including compliance with Medicare requirements.
- Greensborough Road Surgery is currently working towards SMS appointment reminders for patients
- Disclosure to others involved in your health care, including treating doctors and specialists outside this practice. This may occur when you are referred to other doctors or are having medical tests. The information appears in the reports or results returned to us following referrals.
- Our practice actively participates in National and State reminder systems and registers. If you do not wish to participate on these registers, please inform your doctor.
- Due to the requirement of this practice to provide information for accreditation purposes, it may be necessary for your history to be accessed by the deputised accreditation doctor to prove proper recording and storing of patient information. Accreditation takes place every three years and the patient files that are used are chosen at random.

Occasionally, our practice is involved in the training of students and participates in research activities. As a result, your personal information may also be used for the following:

- Disclosure to other doctors in the practice, locums and by registrars attached to the practice for the purpose of patient care and teaching. Please let us know if you do not want your records accessed for these purposes.
- Disclosure for research and quality assurance activities to improve individual and community health care and practice management. You will be informed when such activities are being conducted and you will be given the opportunity to “opt out” of any involvement.

I have read the information above and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling patient information. I understand that I am not obliged to provide any information requested of me, but failure to do so might compromise the quality of the health care and treatment given to me. I understand that if my information is to be used for any other purposes other than those set out above, my consent is required.
I am aware of my right to access the information collected about me, except in some circumstances where access may lead to information legitimately being withheld. I understand that I will be given an explanation in these circumstances. I consent to the handling of my information by the practice for the purpose set out above, subject to any limitations on access or disclosure that I notify this practice.
I confirm that the information that I have provided on this form is correct.

Patient’s Name ……

Signature: ……

D.O.B. ……/……../……

Date: ……/……../……

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Past History

To be given to the doctor.

Mr / Mrs / Miss / Ms / Master / Dr …… ……..
(Given Names) (Surname)

Immunisations

If the patient is a child up to 15 years old, are they fully immunised? **Yes, No Unsure**

If you are over 65 and have not had a Pneumovax or Fluvax, please speak to your doctor and they will explain the advantages to you.

List current medication and dosages (if known):

……
……

Past illnesses, long term health problems and operations:

……
……

Allergies (Drugs and other):

……
……

Family health problems

Mother:

……
……

Father:

……
……

Other:

……

Smoking

Do you smoke? If so, how many cigarettes do you smoke per day?

……

Drinking

Do you drink? If so how many days per week do you drink alcohol?

……