New Patient Information Form

We are committed to providing our patients with the best care. To do this, it is essential that your health record contains complete and accurate information. Please assist us by completing your new patient record form:

Contact Information	
Gender:	
Title:	
Surname:	
First Name:	
Date of Birth:	
Street Address:	
Postal Address: *(if different to above)*	
Home Phone:	
Work Phone:	
Mobile Phone:	
Email:	

Emergency Contact Details	
Name:	Relationship to you:
Home Phone:	
Mobile Phone:	

Next of Kin	
Name:	Relationship to you:
Home Phone:	
Mobile Phone:	

Healthcare Identifiers

Medicare Number: _____ Ref: _____ Expiry: ___/_____

Dept. of Veterans' Affairs File Number: _____ ☐ Gold ☐ White

Concession (Pension/Health Care) Card Number: _____ Expiry: ___/_____

Cultural Identity

Country of birth: _____

Preferred Language: _____

To assist with health initiatives - are you Aboriginal and/or Torres Strait Islander?

☐ No ☐ Yes – Aboriginal ☐ Yes - Torres Strait Islander ☐ Yes - Aboriginal and Torres Strait Islander

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As Australia is a genuinely multicultural society, and to tailor appropriate care, encourage understanding and appreciation between people from different nationalities and cultures - do you identify as someone from a culturally and/or linguistic diverse background?

☐ No

☐ Yes - Please elaborate _____

If yes, do you require an interpreter service? ☐ No ☐ Yes

Your Health Information

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

☐ No

☐ Ceased - date_____

☐ Yes - how many ___ day / ___ week

Alcohol

☐ No

☐ Yes - how many ___ day / ___ week / ___ month

Recreational Drug Use

☐ No

☐ Yes - type_____ frequency _____

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Patient Consent

Please read this consent form carefully prior to signing.

Ramjan Health Services Pty Ltd ABN 75 634 732 308 (trading as Warragul Family Medicine) collects personal information about you in order to provide you with the best service experience possible on the website and for our internal business purposes that form part of normal business practices and for purposes otherwise set out in our Privacy Policy at https://www.warragulfamilymedicine.com.au/. This information may also be disclosed to third parties that help us deliver our services or as required by law.

Our Privacy Policy explains how we will collect, use, store and disclose your personal information, the consequences for you if we do not collect this information, how to access or correct your personal information, and how to lodge a privacy complaint.

To obtain further information, you can contact our designated Privacy Officer, Jo Fishwick, by calling (03) 5622 2973 or emailing practicemanager@warragulfamilymedicine.com.au.

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 within the Privacy Policy including contact via SMS to my mobile phone number, post, email or telephone with reminders to help me maintain my health, for example preventative care and early case detection reminders (IE: vaccinations, cervical screening tests), appointment reminders and practice updates. 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.

☐ I certify that I have completed this form completely and accurately to the best of my knowledge

Patient name: (please print) _____

Signature: _____ Date: _____

If not patient signing - your name (please print) _____

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

PRACTICE USE ONLY:

Witnessed by: (staff signature)_____