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

Title:	
Surname:	
First Name:	
Middle Name:	
Date of Birth:	
Gender:	
Street Address:	
Postal Address:	
Home Phone:	
Work Phone:	
Mobile Phone:	Consent to SMS: ☐ Yes ☐ No
Email:	
Marital Status:	Occupation:

Healthcare Identifiers

Medicare Number: _ _ _ _ - _ _ _ _ _ - _ Ref: __ Expiry: ___/_____

Concession Pension Card Number: _____ Expiry: ___/___/____

Concession Health Care Card Number: _____ Expiry: ___/___/____

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

Private Health Insurance Name: _____ No: _____

My Health Record (MHR): ☐ Yes ☐ No Consent to upload information to MHR: ☐ Yes ☐ No

Cultural Identity

Country of Birth:

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

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

Emergency Contact Details

Name:	Relationship to you:
Home Phone:	Mobile Phone:

Next of Kin

Name:	Relationship to you:
Home Phone:	Mobile Phone:

How did you find out about WAMC

Friend / Relative / Internet / Driving past / Newspaper / Other

Why did you choose us?

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Your Health Information: Name: DOB:

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?

☐ Asthma ☐ Diabetes

☐ Hypertension ☐ Chronic Illness

☐ Other – provide details:

☐ Surgery – provide details:

HAVE YOU HAD ANY VACCINATIONS?

☐ No ☐ Yes – 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 _____

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:

Medical Power of Attorney / Medical Decision Maker / Financial Power of Attorney

☐ Yes ☐ No

If yes please attach paperwork or provide at a later date

Do you have any Specialist doctors or Allied Health professionals who provide care to you?

☐ Yes ☐ No

If yes please provide name/s:

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Reminders and Privacy	
Our practice uses a reminder system for health and preventative care. We may send you reminders by post, telephone or SMS. This practice operates in accordance with the Australian Privacy Principles. We will treat your information as private and confidential. We will only disclose it for purposes directly related to your health care. There are circumstances where we may be required or permitted to disclose your information to 3rd parties, e.g. to Medicare, Police, courts of law, hospitals or debt collection agencies. The practice has a comprehensive privacy policy, available at Reception and our website.	I have read and understand the information provided and agree to be contacted for Reminders and for my information to be shared for my healthcare purposes **Initials:**
Booking Appointments and Cancellation Policy	
We require all patients to attend for a consultation with their GP for all health needs, including results, referrals and prescriptions. We have appointments for 10 minutes, 20 minutes and longer in some circumstances. It is very helpful in managing the flow of appointments for patients to book appointments according to the complexity of their health issues and the time required. We strive to keep to our appointment times and would request that patients arrive on time for appointments. If unexpected delay is known, please contact Reception before the appointment time. If you cannot make your scheduled appointment we ask that you contact the practice as early as possible, so we can allocate the appointment to another patient. Failure to provide more than 4 hours' notice may incur a cancellation fee. **Please do not notify our practice via email.**	I have read and understand the Booking Appointments and Cancellation Policy **Initials:**
Terms and Conditions	
WAMC is a private billing clinic, fees are payable on the day of consultation, we accept cash, credit or EFTPOS cards. If an account is not paid on the day of consultation a $10 account keeping fee will be incurred. In the event that a Work Cover or TAC claims are rejected, the patient accepts full liability for these accounts. There are some consultations where the Medicare fee is not claimable. If an overdue account is referred to a collection agency or solicitors, the patient will be liable for all legal costs and commission arising. **Saturday mornings incur a $10 surcharge.**	I have read and understand the Terms and Conditions policy and agree to pay my account at the time of consultation **Initials:**
Third Party Consent	
Our practice is a teaching venue and there may be times when students are onsite to complete clinical placement. Your written consent will be requested and recorded prior to the consultation, if you agree. If you request to have a 3rd party present in a consultation, your verbal request/consent will be noted in your health record.	I have read and understand that I have the right to request or deny a 3rd party presence **Initials:**

Patient name: (please print) _____

Signature: _____ Date: _____

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

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

New Patient Information Form

ABN 97 718 969 750

65-67 Wicklow Avenue Croydon, 3136 VIC
P: (03) 9725 1244 F: (03) 9723 8615

All Correspondence to:
PO Box 1092 Croydon 3136 VIC

Request for Medical Records Transfer

Dear Doctor: _____
Practice Name: _____
Address: _____
_____

Patient Details

Names: _____ D.O.B ___/___/_____
Names: _____ D.O.B ___/___/_____
Names: _____ D.O.B ___/___/_____
Names: _____ D.O.B ___/___/_____
Current Address: _____
Former address (if changed): _____

Patients Authority

I/we, _____

_____

Request that my/our health summary/patient record be forwarded to the Wicklow Avenue Medical Centre, PO Box 1092 Croydon 3136 VIC

Signature_____Date___/____/_____

[Previous Practice to complete below]

This patient is now attending WAMC. Would you kindly forward their clinical records/ an accurate health summary, with relevant correspondence and results, to assist in the future management of this patient? If sending records via disk, we would request it as an XML file for direct import to Best Practice software. Can you also please complete the information requested below and forward to us with the patients records. Thank you.

TYPE	Never Prepared (Please Tick)	Date Completed
GPMP (Item 721)		
Review of GPMP (732)		
Health Assessment (701-715) **Type Prepare e.g. 4yo, 45-49yo, 75+yo**		
Team Care Arrangement (723)		
Review of Team Care Arrangement (732)		
Mental Health Care Plan (2700, 2701, 2715)		
Review Mental Health Care Plan (2712)		