Village Clinic

The Right Advice Towards Good Health

New Patient Information

Mr Mrs Ms Miss Mst Dr (circle) Surname: ____

First Name: ___________________Middle Name:____________________ Known As: _______________

Date Of Birth: ____/____/____ Sex: Male / Female Country of Birth :________________

Age: ___Yrs/months

Are you? Aboriginal: Yes☐ No ☐ Torres Straight Islander :Yes☐ No ☐

Residential Address: ____

____ Post Code: _____________________

Postal Address: ____

____ Post Code: _____________________

Home Ph: _________________ Work Ph: _________________ Mobile: ___________________________

Email Address: _______________________________________ Consent to contact by SMS☐

Consent to Telehealth Consultation if required ☐

Medicare No: ________________________________Ref. No.______ Expiry: _____________________

Pension/HCC No: _______________Expiry: ____________ Type: Pension / HCC / Snr HCC (circle)

DVA No: ______________________Expiry: ____________ Type: White / Gold / Lilac / Orange (circle)

Private Health Fund: ___________________________ No: _________________ Expiry: ____________

Level of Cover: Top / Intermediate / Basic Do you have Extras Cover? Yes / No

Do you have Ambulance Cover: Yes / No

**Please note that your Pension/Health Care Card only covers initial emergency transport. If you require transport to another hospital or facility, you will not be covered. Please contact Ambulance Victoria for more information.*

Occupation: ____

Marital Status: ☐ Single ☐ Married ☐ De facto ☐ Separated ☐ Divorced ☐ Widowed

Next of Kin: ____

Relationship (ie partner, son, sister etc)____________________Phone No: __________________

Emergency Contact Person: ☐ Same as Next of Kin

Name: ____ Phone No: _________________

Relationship (ie partner, son, etc) ________________________

Would you allow access to your records including results to your Relative? Yes □ No □

Book and change appointments on your behalf to your Relative Yes □ No □
If yes, please provide details below:

Name:__________________

Relationship (ie partner, son, sister etc)__________________

Date of Consent to access files:__________________

Do you wish to upload the Health summary to My Health Record Yes □ No □

How did you hear about our clinic?

Friends or family / Yellow Pages / Advertising / Google/ Others _______________________

Medical History:

Height: ____________ cm Weight: __________ Kg

Smoking Status: ☐ Non Smoker ☐ Ex-Smoker ☐ Smoker _____ cigarettes per day

Alcohol Intake: ☐ Non Drinker ☐ Occasional Drinker ☐ ____ drinks per day
____ days per week

Current Medications:____

____

Allergies / Adverse drug reactions: ____

Reaction(s): ____

Brief Medical History:____

____

Family History: ☐ No significant family History ☐ Unknown (eg. Adopted)

Mother Alive? ☐ Yes ☐ No Age at death? _____ Cause of death? ________________

Father Alive? ☐ Yes ☐ No Age at death? _____ Cause of death? ________________

Significant Family History:

Maternal: ☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke
☐ Depression ☐ Colon Cancer ☐ Breast Cancer ☐ Other ______________
Paternal: ☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke ☐ Depression ☐
Colon Cancer ☐ Other ______________

Please carefully read the information on our Terms of Payment and Personal Health Information,

sign and date <u>BOTH</u> parts where indicated (top and bottom of page).

Terms of Payment

1. Payment is required at the time of consultation.
2. Accounts referred to a collection agency will have all costs and commission added to the due amount.
3. A fee of $25 will be charged for failing to attend booked appointments. At least 3hrs notice is required for any cancellations.

Signed ___________________________________ Date _________________________

Notice for Patients

Your **Personal Health Information** and your **Medical Record** may be collected, used and disclosed for the following reasons.

- For communicating relevant information with other treating doctors, specialists or allied health professionals
- For follow up reminder/recall notices
- Accounting/Medicare/Health Insurance procedures
- Quality Assurance activities such as accreditation
- For disease notification as required by law (eg infectious diseases)
- For use by all doctors in this group practice when consulting with you.
- For legal related disclosure as required by a court of law (eg. Subpoena, court order, suspected child abuse)
- For research purposes (de-identified, meaning you are not able to be identified from the information given) for example: PRODA primary health network software.

Your medical record is a confidential document. It is the policy of this practice to maintain security of personal health information at all times and to ensure that this information is only available to authorised members of staff.

If you have any concerns or wish to restrict access to your personal health information please discuss these with your doctor or receptionist. This practice adheres to principles of the RACGP Handbook for the Management of Health Information in Private Medical Practice and has a written policy, which is available to all patients for inspection.

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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 (which is available on request).

I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to me.

I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.

I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.

I consent to the handling of my information by this practice for the purposes set out above subject to any limitations on access or disclosure that I notify this practice of.

I consent to Telehealth consultation provide to me by my practitioner and agree to the assignment of the Medicare benefit directly to the provider (Bulk Bill).

Signed:_______________________________________ Date: _______________________

Name:_______________________________________ (please print)

Please note: Patients above the age of 14year need to sign the notice for patients