**Title**: **\_\_\_\_\_\_ \*Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Middle Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*Date of birth:**  \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ **\*Birth Sex: Male Female**

**\*Gender Identity: Male Female Non Binary Gender Diverse Transgender**

**Different Identity \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*Address**:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*Home Phone:** (\_\_ \_\_) \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ **Work Number:** (\_\_ \_\_) \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_

**\*Mobile:** \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \***Preferred number for contact?**  **Home** **Work Mobile**

**\* What nationality do you identify as?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you require an interpreter? Yes No \*If so, what language do you speak?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If applicable, please choose one of the following: Do you identify as Aboriginal? Torres Strait Islander? Or both?**

**If you answered yes above, are you registered for CTG? Yes No**

**Email address:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Occupation:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*Medicare Number: Ref. No** \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ **Expiry:** \_\_ \_\_/\_\_ \_\_ \_\_ \_\_

**\*Pension**  **Health CC**  **No:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Expiry:** \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_

**DVA (Dept of Veterans' Affair) No:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gold card White card**

**\*If White card, please specify conditions \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*Previous ADF (Australian Defence Force) service?:**

**Never served Current ADF - Permanent Current ADF – Reserves Post ADF – Permanent/Reserves**

**\*Private Health fund:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Membership No:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Religion: Yes No If yes, which faith?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*Next of Kin or Parent/Guardian1:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Relationship:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Phone No:** (\_\_ \_\_) \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_

**\*Emergency Contact or Parent/Guardian2:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(Different from Next of Kin if possible)

**Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_Phone No:** (\_\_ \_\_) \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_

**Is there a primary custodian for the minor (child)?** **Yes No Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you give consent to messages being left with Guardian 2 regarding minor child? Yes No**

**\*I consent to messages being left on my phone with my next of kin emergency contact regarding follow up appointments etc.**

**If you are consulting for a skin/vein matter:**

I would like to have a skin check and further treatment.

I would like to have treatment on my veins.

I see another doctor as my regular GP: Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Practice:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If you are consulting for a GP matter:**

I am intending on becoming a: Permanent Patient Casual Patient Visiting Patient

I am already a patient at GFP in Bargara

If casual/visiting: who is your usual GP

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Practice: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Privacy Statement**

We, and all health providers, are required under legislation to maintain the privacy and confidentiality of all patients. This involves different rights and responsibilities for the staff of the practice and the patient. If you would like any further information relating to the Privacy Act please access https://www.oaic.gov.au/privacy-law/privacy-act/.

In simple terms, this means your information will be collected and disclosed in the following ways for the following reasons:

**It is collected for the following purposes (not exhaustive)**

* To allow for appointments to be booked using practice software
* To comply with confidentiality/accreditation requirements
* For follow-up purposes such as results or preventative healthcare

**How Information is collected:**

* Verbally by practice staff
* In written form eg New Patient Information Form
* In the process of providing healthcare eg referrals from other doctors

**Who it is disclosed to:**

* Other health professionals in the provision of care eg hospitals, specialists
* For legal related disclosures eg mandatory reporting of abuse/communicable diseases
* For the provision of preventative health eg National Bowel Cancer Screening Program, National Cervical Screening Program

**My Health Record Consent:**

My Health Record is an online summary of key health information that is accessible by all treating health practitioners. Grace Family Practice & Skincare will update information on this service on a regular basis to ensure that other health professionals involved in care, for example specialists and hospitals, will be able to quickly access up to date information about your health.

 Yes, I consent to be involved in My Health Record. No, I do not consent to be involved in My Health Record.

**\*SMS Consent:**

I consent for sms reminders regarding appointments **Yes No**

I consent for sms messages regarding clinical reminders and communication **Yes No**

I consent for sms messages regarding health awareness information **Yes No**

 ***\*\*I have read and understand the policies and procedures of Grace Family Practice & Skincare.*** ­­­­ \* please see attached Practice Information sheet, see reception if not attached

**\*Form completed by: Name: (Please print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*Date**:\_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_

**\*If signing on behalf of a minor/child, what is your relationship?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***\*\*\*Please hand this Patient Information form back to reception asap for data entry prior to seeing doctor.***

**Medical History/Demographics Form**

**\*\*Please fill out the following questions regarding your medical history:**

**\*Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are you under any Medical Specialists?** **Y N If so; who/conditions:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have any allergies? -** Medications, non drug or other **(please specify). If nil known allergies, please tick box**

|  |  |  |  |
| --- | --- | --- | --- |
| **Allergy:** | **Reaction + severity:****mild, moderate or severe** | **Allergy:** | **Reaction + severity:****mild, moderate or severe** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Family History**

**Mother:** Alive / Deceased Age: \_\_\_\_\_\_\_\_ Cause: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Father:** Alive / Deceased Age: \_\_\_\_\_\_\_\_ Cause: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Significant other family history: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medical History: Tick box if you have ever had any of the following:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Respiratory Conditions** | **✓** | **Neurological Conditions** | **✓** | **Liver Conditions** (specify): |
| Emphysema/Chronic Bronchitis |  | Stroke |  |
| Asthma |  | TIA/Mini stroke |  | **Kidney Conditions** (specify): |
| Other (specify): | Dementia/Alzheimer’s |  |
| Epilepsy/seizure conditions |  | **Skin Conditions** (specify): |
| **Cardiac Conditions** | Other (specify): |
| Heart attack |  | **Eye Conditions** (specify): |
| Angina/chest pain |  | **Cancer** |
| Heart failure/CCF |  | Current |  | Previous |  | **Muscular Conditions** (specify): |
| Abnormal rhythms (specify): |  | Location/Type (specify): |
| **Bone/Skeletal Conditions** (specify): |
| High blood pressure |  |
| Other(specify):  | **Stomach/Intestinal** (specify): |
| **Communicable Diseases** |
| **Endocrine/Hormonal Conditions** | HIV/AIDS |  | Other relevant(specify):  |
| Diabetes: Type 1  |  | Type 2 |  | Hepatitis: Current |  | Previous |  |
| Thyroid conditions (specify):  | Hep A |  | Hep B |  | Hep C |  |
| Other (specify): | Other (specify): |

**Marital status: Single Married Divorced Separated De facto Widowed Child (under 16)**

**Do you have an Advanced Health Directive?** **Y N** *\*Please provide a copy for filing*

**Do you have an Enduring Power of Attorney? If so who? Y N** *\*Please provide a copy for filing*

**Name :**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_**Relationship:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ **Phone No:** (\_\_ \_\_) \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_

**Smoking History: Never Current -No. per day\_\_\_\_\_\_\_\_\_ Ex-Smoker -yrs since quitting\_\_\_\_\_\_\_\_**

**Alcohol History: No. Days per week alcohol consumed\_\_\_\_\_\_\_\_\_\_\_\_\_ No. Drinks per day\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Weight (kg): \_\_\_\_\_\_\_\_\_\_\_\_ Height:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**