EAST ADELAIDE HEALTHcare

## New Patient Information Form

**Surname:** _____ Mr/Mrs/Ms/Miss/Mast

**First Name:** _____ **Date of Birth:** _____

**Street Address:** _____

**Suburb:** _____ **Post Code:** _____

**Occupation:** _____

**Are you Aboriginal or Torres Strait Islander?** Aboriginal: Yes/No Torres Strait Islander: Yes/No

**Country of Birth:** _____ **Main Language Spoken:** _____

**Contact Details**

Home Ph: _____ Mobile: _____

Work Ph: _____ Email: _____

**Medicare Number:** __ __ __ __ __ __ __ __ __ __ **Ref No:** ___ **Expiry Date:** _____

**Pension/Health Care Card:** _____ **Expiry Date:** _____

**Commonwealth Seniors Card:** _____ **Expiry Date:** _____

**Veterans Affairs Gold Card:** _____ **Expiry Date:** _____

**Private Health Fund:** _____ **Number:** _____

**Do you have a current WorkCover Claim:**

**Yes/No**

**Employer Details:** _____

**Claim Number:** _____

**Do you have a current Motor Vehicle Accident:**

**Yes/No**

**Claim Number:** _____

**How did you hear about our Practice? Please circle**

**Family** **Friend** **Yellow Pages** **EAHC Website** **Other:** _____

**Please Note:** East Adelaide Healthcare is a private billing practice. **Bulk-billing is not routine and you will receive an account for your visit.** Accounts paid on the day of consult will be charged at a discounted fee.

*I have read the above fee policy and accept the conditions described:*

Signed: _____ Date: _____

**Full Name:** _____ **D.O.B:** _____

**Person Responsible for this Account (please circle)**

**Self**

**Parent/Guardian:** Name: _____

Address: _____

Date of Birth: _____/_____/_____

Medicare No: __ __ __ __ __ __ __ __ __ __ Ref No: ___

Contact No. _____

## Disclosure of Personal Information

**Emergency Contact**

In case of emergency please list a family member or contact person to whom you authorise the doctor/practice to contact:

Name: _____ Relationship to you: _____

Home Ph: _____ Mobile: _____ Work Ph: _____

**Next of Kin**

Same as above: Yes / No

Name: _____ Relationship to you: _____

Home Ph: _____ Mobile: _____ Work Ph: _____

**Clinical Information Consent**

It is the policy of East Adelaide Healthcare to only disclose your clinical information to yourself or another practitioner who may be involved in your treatment for a specific reason (eg. Specialists you have been referred to).
If you wish to authorise a specific family member or contact person to call on your behalf and discuss your clinical information (including your pathology and radiology results) please specify below:

Name: _____ Relationship to you: _____

Signed: _____ Date: _____

**The above details will be kept in your file. If for any reason you wish for the authorisations to change, you must advise the Practice in writing.**

## Privacy Consent

**I consent to East Adelaide Healthcare using the information it holds about me to send me information about RESEARCH STUDIES pertinent to my health needs □ YES □ NO**

**Signed: _____ Date: _____**

**The National Privacy Principles in the Privacy Act sets out how this Practice should collect, use, keep secure and disclose personal information. (A copy of this is enclosed in your new patient folder).**

## SMS Consent

I consent to East Adelaide Healthcare contacting me via SMS message for the purpose of:

- Appointment Reminders
- Recalls
- Test Results

I acknowledge that this is an additional service offered by EAHC and that it is my responsibility to follow up on test results and appointments. If you have not received an SMS message within one (1) week of that test being performed, you should always contact EAHC to get the results.

I understand that I can cancel the SMS message facility at any time by completing the SMS Consent Form again, indicating my refusal.

***Please be aware that refusal of SMS messages for any one of these services (appointment reminders, recalls, or test results) will mean that you will be ineligible for all three types of SMS messages.***

**Please tick below your consent or refusal for SMS:**

[ ] CONSENT Mobile phone number for SMS messages: _____

[ ] REFUSAL I will opt out of all three types of SMS messaging.

**If this New Patient Information form is for your child that is under the age of 16, please tick below your consent or refusal for SMS:**

[ ] I CONSENT to East Adelaide Healthcare contacting me via SMS message for my child that is under the age of 16:

Child's Name:_____

Your Name: _____

Mobile phone number for SMS messages: _____

[ ] REFUSAL I will opt my child out of all three types of SMS messaging.

SIgned: _____ Date: _____/_____/_____

*Your contact details should be kept up to date and the practice advised of any changes.*
*Please remember the privacy settings on your device are your responsibility.*

## Clinical Information

**Full Name:** _____ **D.O.B:** _____

**Past Conditions/Operations/Accidents**: _____ **Year:** __

_____ **Year:** __

_____ **Year:** __

_____ **Year:** __

_____ **Year:** __

**Disabilities:** _____ **Year:** _____

**Are you seeing any other medical practitioners/specialists?** _____

**Family History - i.e. high blood pressure,cancer, diabetes etc**

Mother: _____ Siblings: _____

Father: _____ Other: _____

**Current Medications**
**(including over the counter medications/vitamins)**

_____

_____

_____

_____

**Allergies**
**(food, medications etc)**

_____

_____

_____

_____

**Smoking**

Smoker Y/N Ex-Smoker Y/N

Year Started: _____ Year Stopped: _____

**Alcohol**

No. of standard drinks:

Per Day: _____ Per Week: _____

**Immunisations/Checks – have you had the following (please circle)**

Tetanus Injection:
Y / N / Unsure date: _____

Flu Vax
Y / N / Unsure date: _____

Cholesterol Check
Y / N / Unsure date: _____

Blood Pressure Check
Y / N / Unsure date: _____

Prostate Check
Y / N / Unsure date: _____

Pap Smear
Y / N / Unsure date: _____

Skin Check
Y / N / Unsure date: _____

Bowel Cancer Screening
Y / N / Unsure date: _____