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:

Your Name: _____

[ ] 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: _____

Do you have an Advanced Care Directive? (please circle): Y / N / Unsure

If you answered No, would you like to discuss this with your doctor? Y / N