Edgeworth Family Practice

EDGEWORTH FAMILY PRACTICE
NEW PATIENT FORM

□ Mr □ Mrs □ Miss □ Ms □ Master □ Dr

Name_____

DOB _____ / _____ / _____ □ Retired □ Unemployed

Home address: _____ Suburb_____ P/code_____

Mobile number: _____ Work number: _____

Home number: _____ Occupation: _____

I may ask EFP to contact me via email, my address is _____ I confirm I have read the personal information section of the privacy policy □ (please tick)

□ Female □ Male □ Other_____ □ I identify as LGBTIQA+

Marital status: □ Single □ Married □ De facto □ Separated □ Divorced □ Widowed

What country were you born? _____

What country was your Mother born? _____ Please tick if unsure □

What country was your Father born? _____ Please tick if unsure □

Do you identify as (Please tick)

□ Aboriginal □ Torres Strait Islander □ Aboriginal and Torres Strait Islander

Medicare: __ __ __ __ / __ __ __ __ __ /__ Expiry __ __ / __ __ __ __ Number to left of your name- _____

Pension/HCC: __ __ __ / __ __ __ / __ __ __ __ Expiry __ __ / __ __ / __ __ __ __

DVA □ Gold card: __ __ __ __ __ __ __ __ __ Expiry __ __ / __ __ __ __

□ White card: __ __ __ __ __ __ __ __ _ Expiry __ __ / __ __ __ __

EMERGENCY CONTACTS

Next of kin Name: _____ Relationship to you: _____

Address: _____

Home ph.: _____ Mobile ph.: _____

Emergency Contact (If different from NOK) Name: _____

Relationship to you: _____

Address: _____

Home ph.: _____ Mobile ph.: _____

MY HEALTH RECORD

I have registered myself/my child for My Health Record □ YES □ NO

Please ask at Reception if you require information on registering for My Health Record.

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Patient Name: **Date of birth** ___ / ___ / _____

YOUR PRIVACY – PLEASE READ CAREFULLY

This practice collects information for the primary purpose of providing quality healthcare.
To confirm we have the correct patient & to check contact details, each time you present to our practice you will be asked to confirm 3 points of identification. We require you to provide us with your personal details and a full medical history so we may properly assess, diagnose and treat illnesses and medical conditions, ensuring we are proactive in your healthcare. Our clinicians will only request information pertinent to your health care. Your personal information is handled within the guidelines of the *Privacy Act 1988*.
I am a (please circle - **PATIENT** or **PARENT** or **GUARDIAN** or **CARER**) By signing below I am consenting to the collection of my personal information or confirming I have permission to consent on behalf of the abovementioned patient, and confirming I have been issued with a full Privacy Policy to read **(A Practice brochure is attached to the front & a full policy is attached behind this form)**

_____

PRINT FULL NAME SIGNATURE DATE

EFP is bound by the Privacy Act Australia 1988. As such, signed patient consent is required to send electronic reminders (sms). Please read the descriptions below, tick and sign the pertinent consents.

Consent	Description
APPOINTMENT □ YES □ NO	Consent indicates a patient allows reminders to be sent to them regarding their booked appointment from our appointment book or by an automated service Signed_____ Dated __ / __ / ____
CLINCIAL REMINDER □ YES □ NO	Consent indicates a patient allows reminders to be sent for future clinical reminders coming due such as, Immunisation, Care Plans, BP, Cervical screening etc Signed_____ Dated __ / __ / ____
CLINICAL COMMUNICATION □ YES □ NO	Consent indicates a patient allows communications to be sent to them about their investigation results, changes to or collection of a script or important clinical information or updates Signed_____ Dated __ / __ / ____
HEALTH AWARENESS □ YES □ NO	Consent indicates a patient allows communication to be sent to them about a health issue that may be relevant, or important information about the services our practice provides such as a new health initiative, new Doctor commencing work or change of hours etc Signed_____ Dated __ / __ / ____

Upon consent, you will receive a code sent via sms. You will need to supply this code to reception to activate the electronic reminder function of our software.

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Patient Full Name: **Date of birth** ____ / ____ / _____

Do you have a **FAMILY** history of any of these conditions?

Asthma □ Yes □ No **Mental Illness** □ Yes □ No **Diabetes** □ Yes □ No **Stroke** □ Yes □ No

Heart Disease □ Yes □ No **Haemochromatosis** □ Yes □ No **Heart Attack** □ Yes □ No

Cancer □ Yes □ No (if yes, what type) _____

Do you have any Allergies? □ Yes □ No

Allergic to_____ Reaction _____

Allergic to_____ Reaction _____

Allergic to_____ Reaction _____

Allergic to_____ Reaction_____

Are you on any medications? □ Yes □ No

Name of medication	Dosage	Frequency

Do you drink Alcohol?

(Please tick) □ No

□ **Yes-** Days per week? _____ Average drinks per day? _____ □ **Occasional-** Average drinks per session? _____

Do you smoke? □ Never smoked

□ Past smoker Avg. per day? _____ Year started? _____ Year stopped? _____

□ Current smoker Avg. per day? _____ Year started? _____

□ Canabis □ No never □ Yes in the past □ Yes currently