New Patient Information Form **BRAY PARK MEDICAL PRACTICE**

We are committed to providing our patients with the best care. To do this it is essential that your health record is kept up to date and accurate.

Title	☐ Dr ☐ Mr. ☐ Mrs. ☐ Ms ☐ Miss
Surname	
First Name	
Date of Birth	

Street Address	
Suburb and Post Code	
Home Phone	
Work Phone	
Mobile Phone – Can we SMS : YES………. NO………. Please tick	
Email -Please note at this point we are not able to receive or send Emails	

Medicare Number:	**Ref No:**	**Expiry:**
☐ **DVA Gold** ☐ **DVA White** (Please tick which)	**No**:	**Expiry:**
Pension Number	**No**:	**Expiry:**
Health Care Card Number	**No:**	**Expiry:**

Next of Kin (Name and Telephone number)	
Emergency Contact (Name and Telephone number of the person we can contact if needed)	

Workers Compensation Claim No:	Insurance Company:
Employer Name	
Employer Address	
Employer telephone no.	Contact Person:

Patient Background

Australia is a genuinely multicultural society. To tailor appropriate care, encourage understanding and appreciation between people from different ies and nati and backgrounds.

Do you identify as someone from a culturally and/or linguistic diverse background?

☐ No

☐ Yes. Please elaborate:

To assist with health initiatives – are you an Aboriginal or Torres Strait Islander?

☐ No ☐ Yes - Torres Strait Islander

☐ Yes – Aboriginal ☐ Yes – Aboriginal & Torres Strait Islander

Patient Consent for use of Personal Health Information

a) Within the Practice

I give permission for my medical records and personal health information to be shared between doctors of this practice. I understand that all doctors and staff of this practice are covered by confidentiality agreements. I also understand that should I not want my medical or personal information disclosed to other doctors or staff of this practice I need to inform my usual doctor of this issue.

b) Outside the Practice

Furthermore, I agree to allow my doctor to communicate relevant medical details to Specialist Doctors, Hospital Medical Staff, Pathology labs and other Health Care Providers e.g. Physiotherapists, Podiatrists etc involved in my medical care.

This practice from time to time participates in Medical Research projects with outside organisations. We stress that all information shared is ***depersonalised*** (i.e. names of patients are not given)

If you DO NOT want any of your clinical information used in this manner, please indicate with a cross in the following box ☐

c) For Dependant

As Parent/Guardian of I authorise that their health information be also used in the above mentioned manner.

Your Signature -Patient/Parent/Guardian: **Date:**

Reminder Systems

Our practice provides our patients with preventive care and early case detection reminders e.g. immunisations, annual health checks, skin checks and pap smears.

Do you wish to have any relevant health reminders sent to you?	
☐ Yes Mail	☐ No
Are there any health concerns that you would like to receive information on?	

Your Health History

Do you have or have you had a history of the following? (please elaborate)	
☐ Operations	☐ Hypertension
☐ Asthma	☐ Chronic Illness
☐ Diabetes	☐ Other

Do you have any allergies or are you sensitive to drugs or dressings?

☐ No
☐ Yes. Please elaborate:

Immunisations

Have you had the following immunisations? (list date where appropriate)			
Tetanus Booster	☐ Yes. Date:	☐ No	☐ Don't Know
Hepatitis B	☐ Yes. Date:	☐ No	☐ Don't Know
Hepatitis A	☐ Yes. Date:	☐ No	☐ Don't Know
Influenza	☐ Yes. Date:	☐ No	☐ Don't Know
Pneumococcal	☐ Yes. Date:	☐ No	☐ Don't Know
Polio	☐ Yes. Date:	☐ No	☐ Don't Know

Children's Immunisations

If completing this form for a child is their immunisations up to date? ☐ Yes ☐ No

Current Medications

Please list all current medications including over the counter medications, vitamins and minerals:

Family History

Have any members of your family had: (please elaborate)

☐ Heart Disease
☐ Asthma
☐ Diabetes
☐ Mental Illness
☐ Cancer

Social History

Do you use any of the following: (list amount where appropriate)	
Tobacco	☐ No. ☐ Yes. Number ____ day ____ week **or** ☐ Ceased smoking Date________________
Alcohol	☐ No. ☐ Yes. Number ____ day ____ week ____ month
Drug Use	☐ No. ☐ Yes. Type __________________ Frequency __________________

Measurements

Height	_________ cm	
Weight	_________ kg	Blood Pressure

For those 65 years and older. When was the last time you were immunised?			
Influenza	Date:	☐ Not sure	☐ Never
Pneumococcal pneumonia	Date:	☐ Not sure	☐ Never
Females When did you last have?			
Pap Smear	Date:	☐ Not sure	☐ Never
Breast Check	Date:	☐ Not sure	☐ Never
Males When did you last have?			
Overall Checkup	Date:	☐ Not sure	☐ Never