

MUDGEERABA GENERAL PRACTICE
ADULT NEW PATIENT FORM.....Welcome to our practice

Please complete this form and bring to reception 10 minutes before your initial consultation

We need this information to provide you with the best quality of care. Our practice follows the guidelines of The Royal Australian College of General Practitioners Handbook for the management of health information in private medical practice. This means your personal health information is kept private and secure, as required by federal and state privacy laws. If you wish to review our full privacy policy please request a copy from one of our reception staff.

PATIENT DETAILS

Surname _____ Given Names _____ Title _____

Date of birth ___/___/___ Are you a visitor to this practice Yes No

Are you of Aboriginal or Torres Strait Islander origin? Yes No If Yes, please advise _____

Home address _____

Postal address _____

Phone (home) _____ (work) _____ (mobile) _____

E-mail: _____

Medicare Card Number _____ / _____ Expiry date _____

Veterans' Affairs Card Number _____ Expiry date _____

Health Care Card Number _____ Expiry date _____

Pension Card Number _____ Expiry date _____

EMERGENCY CONTACT (next of kin)

Name _____ Relationship to you _____

Phone (home) _____ (work) _____ (mobile) _____

How did you hear about our practice?

Family/Friends Internet Specialist _____

Signage Yellow pages Other (please specify) _____

Please turn over

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Cancellation Policy

We ask that if you cannot make your scheduled appointment you contact us as early as possible. This will ensure other people do not miss out on available appointments. Failure to give us notice may incur a late cancellation fee.

Privacy Patient Information

To provide a high standard of medical care our practice undertakes research, professional development, and quality assurance/improvement activities. Any person accessing personal health information for this purpose has signed a written confidentiality agreement.

I consent to my health record being reviewed as part of the quality improvement activities at this practice
Yes No

At times some of your medical information may need to be shared with other health care providers. Our practice uses encrypted e-mail as a form of communication with other health professionals, for example, specialists.

I consent to my medical information being transmitted via encrypted e-mail Yes No

Signature of patient _____ Date ____ / ____ / ____

Please advise us if your contact information or Medicare details change.

TRANSFER OF HEALTH INFORMATION

You may have consistently consulted with a GP at another practice. The health information held by that GP may assist us with your future health care needs. You may wish to have a copy or a summary of your health records transferred to this practice. Please ask the receptionist for information about how this can take place.

MUDGEERABA GENERAL PRACTICE
ADULT NEW PATIENT HEALTH SUMMARY

SURNAME _____ GIVEN NAMES _____

Occupation _____ Date of birth ___/___/___

Marital status Single Married Defacto Separated Divorced Widowed

HEIGHT (cm) _____ **WEIGHT (kg)** _____

IMMUNISATIONS

Childhood up to date Yes No Unsure

Adult Tetanus (year) _____ Adult Flu (year) _____ Pneumococcal (year) _____

ALLERGIES, INTOLERANCES & SENSITIVITES (specify type of reaction e.g. rash)

1.	3.
2.	4.

HISTORY OF MEDICAL PROBLEMS (including year of onset or diagnosis)

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

HISTORY OF OPERATIONS (including year)

1.	4.
2.	5.
3.	6.

FAMILY HISTORY

1.	3.
2.	4.

CURRENT MEDICATIONS & DOSAGE (including over the counter medications)

1.	5.
2.	6.
3.	7.
4.	8.

Smoking status Current Ex Never Year started _____ Year stopped _____
Number of cigarettes per day _____

Alcohol How many days a week do you drink alcohol? _____
On days when drinking, number of standard drinks consumed? _____
(one standard drink = 425ml light beer/285ml full strength beer/100ml wine/30ml spirits/60ml port or sherry)

Date of last Pap _____ Date of last Mammogram _____

Thank you for completing this Health Summary....