NEW PATIENT FORM

Patient Details

Title:____________ Surname: _______________________ Middle Initial: ___

First Name: ________________________ Preferred Name: _________________

DOB: __________ Email: ____

Gender at Birth: _______ Gender Identity:________ Pronouns: ____________

Ethnicity: _________________________ Country of Birth: _________________

Do you identify as: Aboriginal / Torres Strait Islander / Both

Home Address: ____

Postal Address: ____

Home Ph: ________________________ Work Ph:_________________________

Mobile: ___________________________

Marital status: ____________________ Occupation: ______________________

Is English your first language? Yes / No Do you require an interpreter? Yes / No

If yes, specify language: ____________ Are you hearing impaired? Yes / No

Billing Information

Medicare No.: ____________________ Ref No.: ________ Exp: __________

Concession CRN: __________________ Type: __________ Exp: __________

DVA No.: _________________________ Colour: ________ Exp: __________

Conditions (White card only):____

Next of Kin Details

First Name: _______________________ Surname: _______________________

Phone No.: _______________________ Relationship: ____________________

Address: ____

Emergency Contact Details (if different to NOK)

First Name: _______________________ Surname: _______________________

Phone No.: _______________________ Relationship: ____________________

Medical History

Allergies/ Intolerances: ____

Reactions: ____

Medical Conditions & Diseases: _______________________________________

____

Current Medications & Doses: ____

____

Are you a current smoker?: Yes / No If yes, how many per day?: _________

Are you a previous smoker?: Yes / No If yes, what year did you quit?: ______

Do you consume alcohol?: Yes / No

How many days per week?: __________ How many drinks per day?: _______

Do you use illegal substances/ drugs?: Yes / No

If yes, please list type and frequency: ________________________________

Privacy & Consent

By signing below, you (as patient/ guardian) are consenting that on obtaining your personal information it may be used or disclosed by providers/ staff at this facility for the following purposes:

- Follow up reminder/ recall notices for treatment and preventative health care including phone, post, email and SMS.
- To communicate with you electronically regarding your appointments, health information and to respond to email enquiries.
- For accounting procedures and the collection of professional fees
- The diagnosis and treatment of my condition, including the communication of relevant information to staff/ providers at this facility, specialists and other health care providers to ensure quality care is provided
- For legal related disclosures required by the court of law, mandatory reporting of neglect or abuse, and for disease notification as required by law
- For reporting of records and results to the Australian Immunisation Register and the National Cancer Screening Register
- To a third party to conduct quality improvement activities
- For use when seeking treatment by other doctors/ providers in this facility
- For obtaining medical records, previous clinic reports, results and management plans from other medical practitioners, institutions, laboratories and other third-party organisations.
- To inform the next of kin identified in my patient information of the outcome of treatment or to obtain consent to necessary treatment when I am not able to provide such consent
- To contact your emergency contact in the case of an emergency relating to your health care, or if the practice has been unable to contact you directly
- For messages to be left on your telephone answering service or message bank regarding matters of your health.

By signing below, you (as patient/ guardian) also acknowledge the following:

- The providers at St James Family Medical & St James Specialist offer mixed billing services and some private fee's apply. You are responsible for payment in full at the conclusion of your appointment.
- You understand that St James Family Medical & St James Specialist complies with the Australian Privacy Act (1988).
- You understand that email is not a secure form of communication, and confidentiality cannot be guaranteed. Please be aware that your personal information could potentially be compromised or accessed by someone other than the intended recipient. Patients communicating through email do so at their own risk.

Patient/ Guardian Signature: __________________________ Date: _________

Guardian Name (if patient is under 16 years): _____________________________