# KENMORE CLINICS – GENERAL PRACTICE
# **Patient Information Form**

**We are committed to providing our patients with the best care, to do this it is essential that your medical records are up to date and accurate.**

| | | | |
|---|---|---|---|
| **Title (please circle)** | Mr Mrs Ms Miss Mst Dr Other …… | | |
| **First Name** | | | |
| **Surname** | | | |
| **Preferred Name** | | | |
| **Date of Birth** | Country of Birth: | | |
| **Sex** | Male Female | | |
| **Marital Status (please circle)** | Single Married Widowed Divorced Defacto Separated | | |
| **Medicare Number** | **Ref** ☐ | **Expiry Date** | |
| **Concession Card – Issued by Centrelink** | | | |
| Pension Card Number | | **Expiry Date** | |
| Health Care Card Number | | **Expiry Date** | |
| DVA - Gold / White | | **Expiry Date** | |
| Seniors Health Card (Discount consultation rate) | | **Expiry Date** | |
| **Occupation** | | | |
| **Residential Address** | | | |
| **Home Phone** | | **Mobile** | |
| **Email** | | | |
| **Postal Address (if different from Residential)** | | | |
| **Next of Kin** | Name: D.O.B:<br>Phone:<br>Relationship: | | |
| **Emergency Contact**<br>☐ Same as Next of Kin<br>☐ Other - complete → | Name:<br>Phone:<br>Relationship: | | |
| **USUAL DOCTOR** | If you usually attend another practice please complete the following: | | |
| **Doctor's Name or Clinic Name** | | | |
| **Address** | | | |
| **Phone** | | | |

**Health Initiatives:**

Are you? ☐ Yes, of Aboriginal origin ☐ Yes, of Torres Strait Islander origin
☐ Yes, of both Aboriginal & Torres Strait Islander origin ☐ No, none of the these

Do you have a My Health Record? ☐ Yes ☐ No ☐ Unsure

Do you wish to transfer your regular care to our practice? ☐ Yes ☐ No ☐ Unsure

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| **Name** | | **Date of Birth** | |
|---|---|---|---|

To enable ongoing care and total quality improvement within this practice, and in keeping with the Privacy Act 1988 and National Privacy Principles, we wish to provide you with sufficient information on how your personal health information may be used or disclosed and record your consent or restrictions to this consent.

Your personal health information will only be used for the purposes for which it is collected or as otherwise permitted by law and we respect your right to determine how your personal health information is used or disclosed.

The information we collect may be collected by a number of different methods and examples may include: medical test results, notes from consultations, Medicare and health insurance details, data collected from observations and conversations with you, photographs and details obtained from other health care providers (e.g. specialist correspondence).

By signing below, you (as a patient/guardian) are consenting, that on obtaining your personal health information it may be used or disclosed by the practice for the following purposes:

- Follow up reminder/recall notices for treatment and preventive healthcare.
- For accounting procedures and the collection of professional fees.
- The diagnosis and treatment of any health condition, including the communication of relevant information only, to practice staff, specialists and other healthcare providers to ensure quality care is provided.
- Accreditation and Quality Assurance activities are conducted by professionally trained non-treating GP's and other professionally trained and qualified persons eg. General Practice Managers.
- For legal related disclosure as required by a court of law.
- For the purposes of research only where de-identified information is used.
- To allow medical students and staff to participate in medical training/teaching using only de- identified information.
- For disease notification as required by law.
- For use when seeking treatment by other doctors in this practice.

At all times, we are required to ensure your details are treated with the utmost confidentiality. Your records are very important and we will take all steps necessary to ensure they remain confidential.

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Patient Name: (Please Print) _____

Signature:_____ Date:_____

If not Patient signing -Your name (Please Print)_____

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*Staff use only:*

☐ Data entry complete Chart #: ☐ MD ☐ ODP

☐ Concession card verified

☐ My Health Record Brochure (if required)

☐ Patient Transfer Form (if required)

☐ Checked and complete by Staff (Staff Initials) _____

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| **Name** | | **Date of Birth** | |
|---|---|---|---|

**HEIGHT:**_____ **cm** **WEIGHT:**_____ **kg**

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

☐ Yes ☐ No ☐ Unsure
If Yes, details:_____

**SOCIAL HISTORY:**
Smoke ☐ Non Smoker

☐ Ex Smoker Yr started _____ Yr stopped_____

☐ Light (<5/day) ☐ Mod (5-20/day) ☐ Heavy (>20/day)

☐ Smoker /Day_____ Yr started_____

Drink Alcohol ☐ Non drinker

☐ Drinker Days/week you consume alcohol?_____How many drinks/day?_____

**SIGNIFICANT FAMILY HISTORY:** ☐ Nil known ☐ Unknown

| | | | | |
|---|---|---|---|---|
| Mother | ☐ Diabetes | ☐ Hypertension | ☐ Heart Disease | ☐ Stroke |
| | ☐ Colon Cancer | ☐ Depression | ☐ Breast Cancer | |
| Father | ☐ Diabetes | ☐ Hypertension | ☐ Heart Disease | ☐ Stroke |
| | ☐ Colon Cancer | ☐ Depression | ☐ Prostate Cancer | |

**PERSONAL HEALTH HISTORY:** Do you have or had a history of?

☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Asthma ☐ Cholesterol

☐ Any other Chronic Disease_____

☐ Cancer/tumour (of any type)_____

☐ Operations/procedures/minor surgery_____

☐ Other_____

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*Doctor/Staff use only:*

☐ Reviewed by GP (GP Initials) _____

☐ Data Entry checked and complete by Staff (Staff Initials) _____