GDFMC and Bribie MediPlus are mixed billing practices, patients with pension or DVA Gold Cards will be bulk billed. All Saturday appointments (face to face and phone) regardless of concession status will incur an out of pocket fee.

We need this information to provide the best quality care. This form complies with the RACGP *Standards for General Practices (5th edition)*. This means your personal health information is kept private and secure, as required by federal and state privacy laws. If you have concerns, please leave blank and discuss with your GP.

Please notify us promptly of any changes in your contact details. Accurate contact details help us identify you and your medical records, and allow us to contact you promptly about tests and results.

Patient Details: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Master ☐ Other ________________

Surname: ___________________ **Given Name:** ____________ **Middle Name:** ____________ **Preferred Name:** ___________

Date of Birth: ________________ **Gender:** ☐ Male ☐ Female ☐ Other **Country of Birth:** _________________

Are you of Aboriginal or Torres Strait Islander origin? ☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander

Other cultural background *(e.g. Asian, African etc)* ____________________ **Occupation?** __________________ ☐ **Retired**

Address: ____ **Suburb:** _____________ **Postcode:** _______

Mobile: ____________________ **Home**: _______________ **Email:** ____

How did you find out about our surgery?

☐ Word of Mouth ☐ Website ☐ Drive / Walk Past ☐ Leaflets / Flyers ☐ Newspaper / Magazine ☐ Online Bookings

Medicare No: ________________________ **Ref #** *(next to name)* ______ **Expiry Date:** ________________

Veterans Affairs No: __________________ ☐ Gold ☐ White – Condition/s _______________________________________

☐ **Pension /** ☐ **Healthcare Card No:** ______________________________ **Expiry Date:** ______________

Do you have private health care fund? ☐ Yes ☐ No **Fund Name:** __________________ **Fund Number:** _____________

Next of Kin: _________________________________ **Relationship:** _______________ **Phone:** ___________________

Emergency Contact: _________________________ **Relationship:** _______________ **Phone:** ___________________

Minors	Parent / Guardian Name ____________________________________	Date of Birth: ________________
	Medicare Card No ______________________________	Ref No: _____ Expiry Date: _________

Transfer of health information

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

List allergies and intolerances to medications	**Describe your reaction**
____	______________________________________
____	______________________________________
____	______________________________________

List regular medications and doses, and complementary medicines and doses

____

____

Smoking: Do you smoke? ☐ Yes ☐ No If yes, how many per day? __________

Past Smoking History? ☐ Nil ☐ Light ☐ Moderate ☐ Heavy Which year did you stop smoking? ___________

Alcohol Consumption:
Do you drink alcohol? ☐ Yes ☐ No If yes, how many standard drinks per day?_____ How many days per week? ______

Past Alcohol Consumption: ☐ Nil ☐ Occasional ☐ Moderate ☐ Heavy

Patient History

Please list any operations or previous illnesses: ____

____

Do you know your blood group? ☐ No ☐ Yes If yes, what group are you? ____________________

Female Patients	Have you ever had a Papsmear? ☐ No ☐ Yes Month: _____________ Year: ________
	Are you currently Breastfeeding? ☐ No ☐ Yes

Family History

☐ Unknown *(e.g. Adopted)* ☐ No significant family history

Mother: Still alive ☐ Yes ☐ No If no, Age at Death: _____ Cause of Death: ____________________

☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke ☐ Colon Cancer ☐ Depression ☐ Breast Cancer

☐ Other Cancer *(please specify)* ____

Father: Still alive ☐ Yes ☐ No If no, Age at Death: _____ Cause of Death: ____________________

☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke ☐ Colon Cancer ☐ Depression ☐ Breast Cancer

☐ Other Cancer *(please specify)*

Other immediate family member's significant illnesses:

Relationship: _____________ Condition: ____

Relationship: _____________ Condition: ____

Health Information Collection and Use

As a patient of our practice we require you to provide us with your personal details and a full medical history, so that we may properly assess, diagnose, treat and be proactive in your health care needs.

We aim to protect the privacy and secure storage of your health information. You can request a copy of our privacy policy, which includes information about the collection, use and disclosure of your health information.

We require your consent to collect personal information about you and we use the information you provide in the following ways. Please read this consent form carefully, and sign where indicated below.

- Administrative and billing purposes, including compliance with Medicare and Health Insurance Commission requirements
- Disclosure to others involved in your healthcare including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following referrals.
- Disclosure to other doctors in the practice, locums etc. attached to the practice for the purpose of patient care and teaching.
- For research and quality assurance activities to improve individual and community health care and practice management. Information that does not identify you is used but should information that will identify you be required you will be informed and given the opportunity to "opt out" of any involvement.
- To comply with any legislative or regulatory requirements, e.g. notifiable diseases.
- For information which may be sent to you regarding your health care and management.

Permission - by becoming a patient of Goodwin Drive Family Medical Centre and signing this new patient form you agree and consent to the following:

I consent to the use of my personal health information by Goodwin Drive Family Medical centre and other health care providers involved in my medical treatment and health care within this centre.

I consent to the disclosure of my personal health information by the above-named practice to other health care providers involved directly or indirectly involved in my personal health care or medical treatment including uploading of health information electronically to My Health Record.

Our practice also sends information to the **Australian Childhood Immunisation Register** and **Pap Smear Register**. These registers also send reminders, which can be helpful if you move.

The practice sends reminders by post, email and telephone or SMS for appointments and procedures like vaccinations, cervical screening, health reviews and health awareness campaigns. By signing this permission, you consent to receiving reminders to help you maintain your health.

You can decline to have your health information used in all or some ways outlined above but it may influence our ability to manage your health care to provide the best outcome for you.

I have read the information above and understand the reasons why my information must be collected.

I understand that I am not obliged to provide any information requested of me, but failure to do so may compromise the quality of health care and treatment given to me.

Please note, if you no longer require your appointment, **please call to cancel** so the time may be made available to other patients.
Failure to do so, a minimum of 2 hours prior to your appointment, may incur a fee of $50.00 which is not claimable on Medicare.

Signature *(Patient / Parent / Guardian)*____________________ **Printed Name:** ________________ **Date:** ____________

Office use only: **Entered:** / / 20___ Initials: ___ **Scanned**: / / 20___ Initials: ___ **Filed:** ☐ Yes ☐ No