

EDGEWORTH FAMILY PRACTICE NEW PATIENT FORM

Mr Mrs Miss Ms Master Dr

Name _____

DOB ____ / ____ / ____ Retired Unemployed

Home address: _____ Suburb _____ P/code _____

Mobile number: _____ Work number: _____

Home number: _____ Occupation: _____

I may ask EFP to contact me via email, my address is _____ I confirm I
have read the personal information section of the privacy policy (please tick)

Female Male Other _____ I identify as LGBTIQA+

Marital status: Single Married De facto Separated Divorced Widowed

What country were you born? _____

What country was your Mother born? _____ Please tick if unsure

What country was your Father born? _____ Please tick if unsure

Do you identify as (Please tick)

Aboriginal Torres Strait Islander Aboriginal and Torres Strait Islander

Medicare: ____ / ____ / ____ Expiry ____ / ____ Number to left of your name- ____

Pension/HCC: ____ / ____ / ____ Expiry ____ / ____ / ____

DVA Gold card: _____ Expiry ____ / ____

White card: _____ Expiry ____ / ____

EMERGENCY CONTACTS

Next of kin Name: _____ Relationship to you: _____

Address: _____

Home ph.: _____ Mobile ph.: _____

Emergency Contact (If different from NOK) Name: _____

Relationship to you: _____

Address: _____

Home ph.: _____ Mobile ph.: _____

MY HEALTH RECORD

I have registered myself/my child for My Health Record YES NO

Please ask at Reception if you require information on registering for My Health Record.

EDGEWORTH FAMILY PRACTICE NEW PATIENT FORM

Patient Name: _____

Date of birth ___ / ___ / _____

YOUR PRIVACY – PLEASE READ CAREFULLY

This practice collects information for the primary purpose of providing quality healthcare.

To confirm we have the correct patient & to check contact details, each time you present to our practice you will be asked to confirm 3 points of identification. We require you to provide us with your personal details and a full medical history so we may properly assess, diagnose and treat illnesses and medical conditions, ensuring we are proactive in your healthcare. Our clinicians will only request information pertinent to your health care. Your personal information is handled within the guidelines of the *Privacy Act 1988*.

I am a (please circle - **PATIENT** or **PARENT** or **GUARDIAN** or **CARER**) By signing below I am consenting to the collection of my personal information or confirming I have permission to consent on behalf of the abovementioned patient, and confirming I have been issued with a full Privacy Policy to read **(A Practice brochure is attached to the front & a full policy is attached behind this form)**

PRINT FULL NAME

SIGNATURE

DATE

EFP is bound by the Privacy Act Australia 1988. As such, signed patient consent is required to send electronic reminders (sms).
Please read the descriptions below, tick and sign the pertinent consents.

Consent	Description
APPOINTMENT <input type="checkbox"/> YES <input type="checkbox"/> NO	Consent indicates a patient allows reminders to be sent to them regarding their booked appointment from our appointment book or by an automated service Signed _____ Dated ___ / ___ / ____
CLINICAL REMINDER <input type="checkbox"/> YES <input type="checkbox"/> NO	Consent indicates a patient allows reminders to be sent for future clinical reminders coming due such as, Immunisation, Care Plans, BP, Cervical screening etc Signed _____ Dated ___ / ___ / ____
CLINICAL COMMUNICATION <input type="checkbox"/> YES <input type="checkbox"/> NO	Consent indicates a patient allows communications to be sent to them about their investigation results, changes to or collection of a script or important clinical information or updates Signed _____ Dated ___ / ___ / ____
HEALTH AWARENESS <input type="checkbox"/> YES <input type="checkbox"/> NO	Consent indicates a patient allows communication to be sent to them about a health issue that may be relevant, or important information about the services our practice provides such as a new health initiative, new Doctor commencing work or change of hours etc Signed _____ Dated ___ / ___ / ____

Upon consent, you will receive a code sent via sms. You will need to supply this code to reception to activate the electronic reminder function of our software.

EDGEWORTH FAMILY PRACTICE NEW PATIENT FORM

Patient Full Name: _____

Date of birth ____ / ____ / ____

Do you have a **FAMILY** history of any of these conditions? (Please circle Yes or No)

Asthma Yes / No

Mental Illness Yes / No

Diabetes Yes / No

Stroke Yes No

Heart Disease Yes / No

Haemochromatosis Yes / No

Heart Attack Yes / No

Cancer Yes / No (if yes, what type) _____

Do you have any Allergies? Yes / No

Allergic to _____ Reaction _____

Allergic to _____ Reaction _____

Allergic to _____ Reaction _____

Allergic to _____ Reaction _____

Are you on any Medications? Yes / No (Please circle)

Name of medication

Dosage

Frequency

Do you drink Alcohol?

(Please tick) No

Yes- Days per week? _____ Average drinks per day? _____ **Occasional**- Average drinks per session? _____

Do you smoke? Never smoked

Past smoker Avg. per day? _____ Year started? _____ Year stopped? _____

Current smoker Avg. per day? _____ Year started? _____

Cannabis No never Yes in the past Yes currently