Edgeworth Family Practice

INFORMATION FORM – PLEASE READ & COMPLETE ALL SECTIONS

☐ Mr. ☐ Mrs ☐ Miss ☐ Ms. ☐ Mast ☐ Dr ☐ Prof ☐ Sir ☐ Lady ☐ Br ☐ Sr ☐ Mx ☐ Other

Patient Full Name _____ D.O.B _____ /_____ /_____

Do you have private Health Insurance Yes / No *(Please circle)* Name of fund _____

Do you have a current Enduring Guardian document in place? ☐ Yes *(if so please supply copy)* ☐ No

Home address: _____ Suburb _____ P/code _____

Mobile number: _____ Work number: _____ Home number: _____

Occupation: Are you: ☐ Retired ☐ Unemployed ☐ Student

I can be contacted via email *(please tick)* ☐ Yes ☐ No *(I understand it is my responsibility to update EFP with changes to my details)*

My email address is: (PRINT CLEARLY) _____

- We do not share/supply patients email address with any 3rd party providers -

I confirm, I have read Edgeworth Family Practice privacy policy *(attached to this form or on the website)* ☐ *(please tick)*

Birth Sex: ☐ Female ☐ Male ☐ Other ☐ Unknown

Gender Identity: ☐ Female ☐ Male ☐ Non-Binary ☐ Gender Diverse ☐ Transgender ☐ Different Identity

Pronouns: ☐ She/Her/Hers ☐ He/Him/His ☐ They/Them/Theirs

Marital status: ☐ Single ☐ Married ☐ De facto ☐ Separated ☐ Divorced ☐ Widowed

Country of birth _____ Preferred language _____ Ethnicity _____

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

RECEPTION WILL NEED TO SIGHT YOUR PROOF OF IDENTITY:

Digital drivers licence sighted: ☐ Yes ☐ No Digital Medicare card sighted: ☐ Yes ☐ No

Medicare: _____ /_____ /_____ Expiry _____ /_____ No. to left of 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.: _____

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Patient Full Name_____ D.O.B _____ /_____ /_____

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 *(Please circle)*

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? ☐ 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? _____ Year stopped? _____

Do you smoke Cannabis? ☐ No never ☐ Yes in the past ☐ Yes currently

Do you vape? ☐ Never vaped

☐ Past vaper : Avg. per day? _____ Year started? _____ Year stopped? _____

☐ Current vaper : Avg. per day? _____ Year started? _____ Year stopped? _____

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Patient Full Name_____ D.O.B _____ /_____ /_____

YOUR PRIVACY – PLEASE READ CAREFULLY

PATIENTS 16 & OVER MUST READ & SIGN THEIR OWN FORM

This practice collects information for the primary purpose of providing quality healthcare. To confirm correct patient & contact details, you will be asked to confirm 3 points of identification at each contact. We also require you to provide us with your full medical history so we may properly assess, diagnose and treat illnesses and medical conditions, ensuring we are proactive in your healthcare. Your personal information is handled within the guidelines of the Privacy Act 1988.

I am ***(please underline)*** **PATIENT** or **PARENT** or G**UARDIAN** or **CARER** or **ENDURING GUARDIAN**

I understand EFP may also need to request results, reports and correspondence from other Medical services in the interest of providing me the most holistic health care. By signing below, I am consenting to the collection of my personal information or confirming I have permission to consent on behalf of the above mentioned patient (If acting as GUARDIAN, CARER or EG you must supply documentation for patient file).

I confirm I have been issued with a full Edgeworth Family Practice Privacy Policy to read
(Attached, EFP Privacy Policy & Practice brochure)

NAME OF PATIENT/CONSENTING *(Please write below)*	**SIGNATURE** *(please sign below)*	**DATE**
_____	_____	_____ / _____ / _____

Please read the descriptions below, tick and sign the relevant consent.

Consent	Description
APPOINTMENTS & FEES ☐ YES ☐ NO	Consent indicates this patient allows reminders to be sent regarding booked or changed appointments, payment required or outstanding/DNA fees, from our messaging services (automated & manual). Signed _____ Dated ____ /____ /_____
CLINICAL RECALLS ☐ YES ☐ NO	Consent indicates this patient allows reminders to be sent for future clinical reminders coming due such as, Immunisation, Care Plans, Blood Pressure check, Cervical screening test etc. Signed _____ Dated ____ /____ /_____
CLINICAL COMMUNICATION ☐ YES ☐ 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 ☐ YES ☐ NO	Consent indicates this patient allows communication to be sent to them about a health issue that may be relevant, 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 ____ /____ /_____

You will receive a code via SMS. Please supply this to reception for activation.