New Client Information Form

Date_____/_____/_____

We are committed to providing our clients with the best care. To do this, it is essential that your health record contains complete and accurate information. Please assist us by completing your New Client Registration Form

PERSONAL INFORMATION

FIRST NAME: _____MIDDLE NAME/s: _____

FAMILY NAME: _____

DATE OF BIRTH: _____/_____/_____ GENDER: _____

MOBILE NUMBER: _____ HOME PHONE: _____ WORK NUMBER: _____

HOME ADDRESS: _____

POSTAL ADDRESS (if different to above) _____

EMERGENCY CONTACT DETAILS

NAME: _____ Relationship to You: _____

HOME PHONE: _____ MOBILE PHONE: _____

NEXT OF KIN

NAME: _____ Relationship to You: _____

HOME PHONE: _____ MOBILE PHONE: _____

CULTURAL IDENTITY

INDIGENOUS STATUS: ☐ ABORGINAL ☐ TORRES STRAIT ISLANDER

(Please tick) ☐ BOTH ☐ NON INDIGENOUS ☐ OTHER _____

As Australia is a genuinely multicultural society, and to tailor appropriate care, encourage understanding and appreciation between people from different nationalities and cultures - do you identify as someone from a culturally and/or linguistically diverse background

☐ No ☐ Yes Please elaborate _____

If Yes, do you required an interpreter service? ☐ No ☐ Yes

HEALTHCARE IDENTIFICATION - CARD INFORMATION

MEDICARE CARD NO: __ __ __ __ __ __ __ __ __ __ **REF NO**: ___ EXPIRY DATE: ____/____/_____

CONCESSION CARD NO: _____ EXPIRY DATE: ____/____/_____

PENSION CARD NO: _____ EXPIRY DATE: ____/____/_____

HEALTHCARE CARD NO: _____ EXPIRY DATE: ____/____/_____

DVA CARD NO: _____ ☐ Gold ☐ White EXPIRY DATE: ____/____/_____

PREVIOUS DOCTOR INFORMATION

NAME OF PREVIOUS DOCTOR: _____ PHONE NUMBER: _____

ADDRESS: _____

Clients will need to complete and sign, a medical records transfer request form

YOUR HEALTH INFORMATION

ALLERGY INFORMATION - Do you have any allergies or are you sensitive to drugs or dressings?

☐ No

☐ Yes – provide details: _____

_____

_____

CURRENT MEDICATIONS – Please list all your current medications, including complementary and over-the-counter medicines (e.g. homeopathic medicines such as vitamins and minerals etc.)

_____

_____

_____

MEDICAL HISTORY - Do you have or have you had a history of the following?

- ☐ Surgery – provide details:
- ☐ Asthma
- ☐ Diabetes
- ☐ Hypertension
- ☐ Chronic Illness
- ☐ Other – provide details:

LIFESTYLE RISK FACTOR INFORMATION

Smoking

- ☐ No
- ☐ Ceased – date: _____
- ☐ Yes - how many _____ day / _____ week

Alcohol

- ☐ No
- ☐ Yes - how many _____ day / _____ week / _____ month

Recreational Drug Use

- ☐ No
- ☐ Yes - type _____ frequency _____

Family Health History Information

Have any members of your family had/have:

- ☐ Heart Disease
- ☐ Asthma
- ☐ Diabetes
- ☐ Hypertension (high blood pressure)
- ☐ Mental Illness
- ☐ Cancer – type: _____
- ☐ Other significant - provide details: _____

Patient Consent

Please read this consent form carefully prior to signing.

Armajun AHS collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose and treat illnesses and medical conditions, ensuring we are proactive in your health care. To enable ongoing care, and in keeping with the *Privacy Act 1988* and *Australian Privacy Principles*, we wish to provide you with sufficient information on how your personal information may be used or disclosed and record your consent or restrictions to this consent.

Your personal information will only be used for the purposes for which it was collected or as otherwise permitted by law, and we respect your right to determine how your 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 details, data collected from observations and conversations with you, and details obtained from other health care providers (e.g. specialist correspondence).

By signing below, you (as a client/parent/guardian) are consenting to the collection of your personal information, and that it may be used or disclosed by the practice for the following purposes:

- Administrative purposes in the operation of our general practice.
- Billing purposes, including compliance with Medicare requirements.
- Follow-up reminder/recall notices for treatment and preventative healthcare, frequently issued by a reminder phone call/SMS.
- Disclosure to others involved in your health care, 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 the referrals.
- Accreditation and quality assurance activities to improve individual and community health care and practice management.
- 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.
- To comply with any legislative or regulatory requirements, e.g. notifiable diseases.
- 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.

Please complete the form below if you understand and agree to the following statements in relation to our use, collection, privacy and disclosure of your patient information.

I, _____ have read the information above and/or had it explained to me, and I understand the reasons why my information must be collected, and the purposes for which my information may be used or disclosed. I understand that if my information is to be used for any purpose other than that set out above, my further consent will be obtained.

I, _____ give permission for my personal information to be collected, used and disclosed as described above, including contact via SMS to my mobile phone number. I understand only my relevant personal information, will be provided to allow the above actions to be undertaken and I am free to withdraw, alter or restrict my consent at any time by notifying this practice in writing.

Patient name: (please print) _____

Signature: _____ Date:_____

If not patient signing - your name (please print) _____

Your relationship to patient (e.g. Mother, Father, guardian)_____

PRACTICE USE ONLY:

Witnessed by: (staff signature)_____

Note: The Information provided in this Form is used to set up the client's electronic file.
The Registration sheet is to be scanned into the client's file and then shredded as per Armajun's Policy on Destruction of Scanned Health Care Documents.

Office Use: Operator Initials: _____