WILTON MEDICAL CENTRE

PATIENT INFORMATION FORM

We need this information to provide the best quality care. Our Practice follows the guidelines of the royal Australian College of general Practitioners Handbook for the management of health information in the private medical practice. This means your personal health information is kept private and secure, as required by federal and state privacy laws. This form complies with the RACGP standards.

PATIENT DETAILS

Title: _____ Surname:_____Given Names_____

Date of Birth_____/_____/_____ Male / female / transgender

Medicare No._____Expiry_____Ref_____

Pension / Health Care / Veterans Card _____Expiry_____

Occupation_____

Home Address_____

Postal address _____

Phone Home_____Work _____Mobile_____

Email: _____

Are you Aboriginal or Torres Strait Islander origin ?

No Aboriginal Torres Strait Islander Aboriginal & Torres Strait Islander

Country of Birth_____ Date arrived in Australia_____

Language_____

HEALTH INFORMATION

Do you suffer from any allergies? No Yes (Please list below)

What is the extent of the reaction? _____

Do you take regular medications? No Yes please list

SURGICAL HISTORY: Please list any surgical procedures / operations you have had:

Surgery Procedure: _____Approx Year_____

Surgery Procedure: _____Approx Year_____

MEDICAL HISTORY : Please list any medical conditions you may have/had:

FAMILY HISTORY: Please list any known history (eg Parents/Siblings/Grandparents/Aunts/Uncles):

DIABETES_____HEART ATTACK_____

HYPERTENSION_____CANCER_____

STROKE_____OTHER_____

IMMUNISATIONS Please list any known vaccinations you have had:

ADDICTIONS / SOCIAL HABITS: Please circle

SMOKING NEVER EX: Approx Quit date _____ YES: HOW MANY PER WEEK _____

DRINK ALCOHOL NO YES

If yes, how many per week ?_____ How many per occasion?_____

OTHER: _____NO YES If yes, how often ?_____

FEMALE PATIENTS ONLY: Please list any significant gynaecological history (last pap test etc)

Would you like to receive a regular newsletter from the practice? YES NO

If so how would you like it to be sent to you ? EMAIL LETTER

How would you prefer staff to contact you for recall purposes ? EMAIL PHONE SMS LETTER

EMERGENCY CONTACT DETAILS

Surname: _____Given Names_____

Relationship to you _____Phone/s_____

Address:_____

PRIVACY AND CONFIDENTIALITY

Please read the following information carefully and sign where indicated:

We require you to provide us with personal information and a full medical history so that you can be properly assessed and treated. Your information may be used in the following ways:

Administration and billing purposes of running the medical practice, including compliance with Medicare and HIC requirements.

Disclosure to others involved with your healthcare, including treating Doctors, Specialists and Allied Health. This may occur through referrals to other Doctors, or for medical tests and in the reports or results returned to us through referrals. Our Practice uses a reminder system to improve the quality of your health care. This Practice sends reminders by mail or text messages for procedures such as vaccinations, pap tests and other health reviews.

I consent to being contacted with reminders as part of the quality improvement activities YES NO

I have read and understand the above information in relation to the use of medical information

Signature of patient or guardian:_____Date:_____

IT IS A LEGAL REQUIREMENT THAT WE SIGHT A PHOTO ID

Photo ID Sighted : ID Number _____ Staff Signature: _____