Grace Family Practice & Skincare

Patient Information Form

Title: _____ **Surname:** _____ **First Name:** _____

Middle Name: _____ **Preferred name:** _____

Date of birth: __ __/__ __/__ __ __ __ **Male** ☐ **Female** ☐ **or other** ☐ (please specify) _____

Address: _____ **Post code:** _____

Home Phone: (__ __) __ __ __ __ __ __ __ __ **Work Number:** (__ __) __ __ __ __ __ __ __ __

Mobile: __ __ __ __ __ __ __ __ __ __ **Preferred number for contact? Home** ☐ **Work** ☐ **Mobile** ☐

What is your Ethnic Background (ancestry)? _____

Do you require an interpreter? Yes ☐ **No** ☐ **If yes, what language do you speak?** _____

Are you of Aboriginal origin? Yes ☐ **No** ☐ **Are you of Torres Strait Islander origin? Yes** ☐ **No** ☐ **Both?** ☐

If you answered yes above, are you registered for CTG? Yes ☐ **No** ☐

Email address: _____ **Occupation:** _____

Medicare Number: Ref. No (__) __ __ __ __ __ __ __ __ __ __ __ **Expiry:** __ __/__ __ __ __

Pension ☐ **Health Care card** ☐ **No:** _____ **Expiry:** __ __/__ __/__ __ __ __

DVA (Dept of Veterans' Affair) No: __ __ __ __ __ __ __ __ __ **Gold** ☐ **White** (please supply approval paperwork) ☐

Orange ☐

Previous Australian Defence Force (ADF):

Never served ☐ **Current ADF - Permanent** ☐ **Current ADF – Reserves** ☐ **Part ADF – Permanent/Reserves** ☐

Private Health fund: _____ **Membership No:** _____

Religion: Yes ☐ **No** ☐ **If yes, which faith?** _____

Next of Kin or Parent/Guardian1:_____ **Relationship**_____

Address: _____ **Phone No:** (__ __) __ __ __ __ __ __ __ __

Emergency Contact or Parent/Guardian2:_____ **Relationship:** _____

Address: _____ **Phone No:** (__ __) __ __ __ __ __ __ __ __

I consent to messages being left on my phone ☐ **with my next of kin** ☐ **emergency contact** ☐ **regarding follow up appointments etc.**

Is there a primary custodian for the minor? Yes ☐ **No** ☐ **Name:** _____

Do you give consent to messages being left with Parent/Guardian 2 regarding minor child? Yes ☐ **No** ☐

I am intending on becoming a: Permanent Patient ☐ **Casual Patient** ☐ **Visiting Patient** ☐

*(If you intend on becoming a **permanent patient** of this practice, **you will need to complete a Request for Records Form,** otherwise you may be charged a casual fee)*

Who is your usual / previous GP: _____ **Clinic:** _____

Grace Family Practice & Skincare

Patient Information Form

Marital status: Single ☐ **Married** ☐ **Divorced /Separated** ☐ **De facto** ☐ **Widowed** ☐ **Child (under 16)** ☐

Do you have an Advanced Health Directive? Yes ☐ **No** ☐ **Please provide a copy for filing*

Do you have an Enduring Power of Attorney? If so who? Yes ☐ **No** ☐ **Please provide a copy for filing*

Name: _____ _____ **Relationship:** _____

Address: _____ **Phone No:** (__ __) __ __ __ __ __ __ __ _

Privacy Statement

We, and all health providers, are required under legislation to maintain the privacy and confidentiality of all patients. This involves different rights and responsibilities for the staff of the practice and the patient. If you would like any further information relating to the Privacy Act please access https://www.oaic.gov.au/privacy-law/privacy-act/.

In simple terms, this means your information will be collected and disclosed in the following ways for the following reasons:

It is collected for the following purposes (not exhaustive)

- To allow for appointments to be booked using practice software
- To comply with confidentiality/accreditation requirements
- For follow-up purposes such as results or preventative healthcare

How Information is collected:

- Verbally by practice staff
- In written form eg New Patient Information Form
- In the process of providing healthcare eg referrals from other doctors

Who it is disclosed to:

- Other health professionals in the provision of care eg hospitals, specialists
- For legal related disclosures eg mandatory reporting of abuse/communicable diseases
- For the provision of preventative health eg National Bowel Cancer Screening Program, National Cervical Screening Program

My Health Record Consent:

My Health Record is an online summary of key health information that is accessible by all treating health practitioners. If you haven't opted out of this service, Grace Family Practice & Skincare will update information on this service on a regular basis to ensure that other health professionals involved in care, for example specialists and hospitals, will be able to quickly access up to date information about your health.

SMS Consent:

I consent for sms reminders regarding appointments	**Yes** ☐	**No** ☐
I consent for sms messages regarding clinical reminders and communication	**Yes** ☐	**No** ☐
I consent for sms messages regarding health awareness information	**Yes** ☐	**No** ☐

*****I have read and understand the policies and procedures of Grace Family Practice & Skincare.*** ☐ please see attached

Form completed by: Name: (Please print) _____ **Signed:** _____

Date: __ __/__ __/__ __ __ __ **If signing on behalf of a minor, what is your relationship?** _____