Garden City Family Doctors

Name: _____DOB: _____

Reminder Systems:
Our practice provides our patients with preventive care and early case detection reminders, e.g. immunisations, annual health checks, and pap smears. **Do you wish to have any relevant health reminders sent to you?** Yes No

Your Health History - Do you have or had a history of:

Operations _____

Asthma	Yes	No
Diabetes	Yes	No
Hypertension	Yes	No
Chronic illness	Yes	No

Do you have any allergies or are you sensitive to drugs or dressings:
Yes (If yes please list below) No

_____

Current Medications (including over the counter medications)

_____

Family History - Have any members of your family had any of the following? If so, what family member?

Heart Attack	Anxiety or depression	Liver disease
Stroke	Glandular fever	Kidney disease
Blood clot	Asthma	Osteoporosis
High blood pressure	Diabetes	Cancer
Epilepsy	Eye problems	Hearing loss

Family History – Who do you live with: _____
Social History:

Tobacco: _____ per day / week or Ceased Smoking - date

Alcohol: _____ times per: day / week / month (circle the one applicable)

On these occasions, how many standard drinks do you consume? _____

Height: _____ cms **Weight:** _____ kgs

Blood Pressure: When was the last time your blood pressure was taken? _____

For those 65 years and older: When was the last time you were immunised?

Influenza	Date	_____	Not sure	Never
Pneumococcal pneumonia	Date	_____	Not sure	Never

Females: When did you last have?

Pap smear	Date	_____	Not sure	Never
Breast Check	Date	_____	Not sure	Never

GARDEN CITY FAMILY DOCTORS

NEW PATIENT FORM

Title: (circle) Mr Mrs Miss Ms Dr

First Name:_____ Middle Name: _____

Family Name: _____ Known as: _____

Date of Birth: _____ Gender: M / F

To assist with health initiatives – are you Aboriginal or Torres Strait Islander (please circle)

Yes- Aboriginal Yes – Torres Strait Islander Yes – Both No

Billing

Medicare No: _____/_____ Expiry _____

Health Care Card/Pension No: _____ Expiry _____

Dept Vet' Affairs No: _____White / Gold Expiry_____

Visiting or Plan to be a regular patient? **(please circle)** Visiting / Regular

My Health Record

Do you have My Health Record? Yes / No

If no, would you like to register? Yes / No If yes, please see Reception team member.

Contact Details

Street Address: _____

Suburb: _____ _____ State: _____ Postcode: _____

Home Phone: _____ Mobile: _____ Work: _____

Occupation: _____ Country of Birth: _____

Year of Arrival in AUS: _____ Ethnicity: _____

Spoken Language:_____ Preferred Language: _____ Interpreter Required: Yes / No

Patients Emergency Contact

Name: _____ Relationship to you: _____

Street Address: _____

Phone: _____ Mobile:_____

NATIONAL STATE & TERRITORY REMINDER SYSTEMS:

Consent for contact: Yes / No Same as next of Kin: Yes / No

Our practice provides our patients with preventative care and early detection reminders eg. Immunisations, annual health checks, skin checks & pap smears.

Do you wish to have relevant health reminders sent to you? (please circle) Yes No

GARDEN CITY FAMILY DOCTORS

PATIENT CONSENT FORM

We require your consent to collect personal information about you. Please read this information carefully and sign where indicated below.

This medical practice collects information from you for the primary purpose of providing quality health care.
Your doctor in the course of a consultation may ask personal details and a full medical history so that he/she may properly assess, diagnose, treat and be proactive in your health care needs.
This means information may be used in the following ways:

- Administrative purposes for running the medical centre
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements
- Disclosure to others involved in your health care, including treating doctors and specialists outside the medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to the medical centre
- Disclosure to other doctors in the practice and locums for the purpose of patient care. Please let us know if you do not want your records assessed for these purposes and we will note your chart accordingly
- Disclosure for Practice Accreditation, which is used to improve individual and community health care and practice management. Please let us know if you do not want your records assessed for this purpose and we will note your record accordingly
- Disclosure to a Medical Defense organisation if a medico legal issue arises

I have read the information above and understand the reasons why my information must be collected.
I am also aware that this practice has a privacy policy on handling patient information.

I understand that I am not obliged to provide information requested of me, but failure to do so may compromise the quality of health care and treatment received.

I am aware of my right to access information collected about me, except in some circumstances where access might be legitimately withheld. I understand I will be given an explanation in these circumstances.

I understand that if my information is to be used for any other purpose other than set above, my further consent will be obtained.

I consent to the handling of my information by this practice for the purpose set out above, subject to any limitations on access or disclosure that I notify the practice of.

Signed……Date……

Patient's Name……D.O.B……

SUBMIT YOUR FORM