Carlton Family Medical
88 Rathdowne St Carlton 3053

New Patient Information Form

PLEASE COMPLETE THIS FORM AND RETURN TO RECEPTION
It is essential that your medical records are up to date and accurate

Title		**Prof ☐ Dr ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Mast ☐ Other ☐**	
Surname			
First Name & Middle Name			***Preferred Name***
Date of Birth			
Birth Sex: Male ☐ Female ☐ Unknown ☐ Other ☐		**Occupation**	
Pronouns: She/Her/Hers ☐ He/Him/His ☐ They/Them/Theirs ☐		**Gender Identity: Female ☐ Male ☐ Non-Binary ☐ Gender-Diverse ☐ Transgender ☐ Different Identity ☐:**	
Medicare Card Number		**__ __ __ __ __ __ __ __ __ __ __ Ref. No: ___ Expiry: ___/_____**	
Ethnicity *(Cultural Background)*			
Street Address			
Suburb and Post Code			
Postal Address *(If different from above)*			
Phone Numbers	**Home**	**Work**	**Mobile**
EMAIL ADDRESS			
For administration purposes what is the best form of contact for you?		**Home ☐ Mobile ☐ Work ☐ Email ☐** **We use SMS reminders for appointments. Do you consent to receiving SMS reminders for appointments? Yes ☐ No ☐**	
Next of Kin* (Name & Phone number) ***(Relationship)*** ***Can be overseas phone number**			
Emergency Contact in Australia ***(If different from Next of Kin).*** **Please fill in the name, phone number and relationship of the person we should contact in an emergency**			

To ensure we offer you with all the Medicare funded health initiatives available, please specify whether you are Aboriginal and / or Torres Strait Islander ☐Yes ☐ No

Are you a full time Tertiary Student Yes ☐ if yes Student Number_____
Are you a visitor to Melbourne? Yes ☐ if yes how long are you staying? _____

Reminder Systems:
We occasionally send important health care reminders via emails or letter to our patients (e.g. cervical screening reminders when due, reminders for blood glucose checks for women with previous gestational diabetes, repeat bone density testing for people with osteoporosis.) These are very specific and targeted reminders. We do not send newsletters or advertising mail. If you do not want to receive these reminders please advise your doctor during the consultation to ensure this is documented in the file.

Signature _____ Date _____

Whilst you're here, how did you find us?
Website ☐, Recommendation from another person ☐ Previously a patient at MMC ☐ Other ☐: _____

Last Updated 17 November 2022

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NAME:_____ Date of Birth_____ Today's Date:----------

Do you have any **Allergies** or are you sensitive to drugs or dressings? YES / NO
Please list the medication and reaction (eg. rash/breathing problems/swelling etc)

We occasionally notify our patients about illness prevention interventions. (eg. as when flu vaccine becomes available each year.) If you want to be excluded from these very infrequent and targeted contacts please advise your doctor.

Do YOU PERSONALLY have a history of?	**When did you last have?**
Operation (What, when and side)	**Women** Cervical Screening
Asthma (childhood or active)	Mammogram (over 50 yo.)
High Blood Pressure/High cholesterol/ Gout	**Men** Prostate check (over 50 yo)
Diabetes / Gestational Diabetes (age of onset)	**Men and women** Eye test (Glaucoma/Macular degeneration)
Other (vegan; chronic dis., inherited risk of condition)	**Bowel cancer screen**

Are you up to date with your childhood and school vaccinations? YES / NO

If so, in which State\ Country did you have the Primary Series of vaccines? Victoria / Other :

Year of LAST Influenza vaccination:

Current Medications (including over -the -counter (OTC) medications, vitamins and minerals)

FAMILY HISTORY - Has any member of your immediate & extended family had any of the following?

	Father	Mother	Other		Father	Mother	Other
Diabetes Type 1 or Type 2:				Genetic Illness			
Heart Attack:				Cancers:			
Mental illness:				Premature death:			
Stroke:				Other:			

Do you smoke cigarettes? YES / NO
Do you drink alcohol? YES / NO

Tobacco: _____ cigs per day or Year that you stopped smoking: _____

Alcohol: How many days do you drink each week? _____ How many standard units on each of these days? _____

Any other drug use? YES/ NO_ : _____

Weight: _____ kg (or pounds) **Height:** _____cm (or Feet\inches)

PLEASE GIVE THIS FORM TO THE DOCTOR AT THE BEGINNING OF THE CONSULTATION

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PRIVACY STATEMENT (effective 17.11.2022)
Updated 17th November 2022 and replaces 29th August 2022 version.

Welcome to Carlton Family Medical
To permit ongoing patient care and quality improvements within this Practice, and in keeping with the Privacy Act 1988 and Australian Privacy Principles, we provide information as to how your personal health information may be used or disclosed and we record your consent or restrictions to this consent. In the event that you withhold your consent in part or in full, we reserve the right to withdraw or not provide professional services to you or your dependents. Your personal health information will only be used for the purposes for which it was collected or as otherwise permitted by the law. The information we collect may be collected by a number of different methods and examples may include medical test results, consultation notes, Medicare and Health Insurance details, data collected from observations and conversations with you, and details from other health care providers (such as Specialist's correspondence) and Regulatory Authorities as well as collateral history from someone familiar with your background in certain instances.

By signing below, you (as a patient, parent or guardian) are consenting to the use and disclosure of your personal health information or the health information of your child or ward by this practice for the following purposes:

1) The diagnosis and treatment of any actual or potential health condition, including the communication of relevant information to the Practice Staff, Specialists, and other Health Care Providers to ensure safety and quality of care;
2) For the use of other doctors in this Practice for the provision of care where it is impractical for the primary Practitioner to provide that care;
3) To provide reminder and recall notices for treatment and/or preventive health care;
4) For accounting procedures and the collection of provisional fees;
5) For Accreditation and Quality Assurance activities that may be conducted by professionally trained non-treating GPs and other trained and entrusted individuals such as Practice Managers and Practice Nurses;
6) For research and teaching purposes (any such information will be de-identified first)
7) For in-house staff training inclusive of medical student education (using de-identified information);
8) For disclosure as required by law such as subpoena or mandatory disease notification;
9) For the possible provision of professional courtesies such as notifying you of changes to Practice location, Practice policies, appointment arrangements and operational details which may affect you.

Where failure to disclose information may place you or another person at risk of serious harm, we reserve the right to make such a disclosure without necessarily seeking your consent. Within the provisions enumerated above, we will take all reasonable measures to ensure the security and confidentiality of your personal health information. This Practice has no arrangement or intention of transmitting information regarding any patient's record to any Overseas Organisation or entity without prior written consent.

By signing this consent form you also undertake to notify this Practice of any changes with your contact details as soon as practicable and to notify this Practice promptly in writing if you should decide to no longer seek any further professional services or contact.

I, _____ give my permission for my personal health information (or the health information of my child or ward) to be collected, used and disclosed as described above. I understand that only relevant personal health information will be disclosed to allow the above actions to be undertaken and I am free to withdraw or modify my consent in any future time by notification to the Practice in writing. In withdrawing or modifying my consent, I understand that this Practice and its practitioners are not obliged to continue to provide services to myself or my wards if it is deemed unsuitable to do so.

To assist me to recognise any update, I understand that the most recent Privacy Statement will be displayed in the Upstairs Waiting Room and at Reception downstairs and the date of change will be displayed on the Privacy Statement itself. I agree that I have been given opportunity to ask questions by the Practitioner regarding the issues raised above and any such questions have been answered to my satisfaction. I also understand that from time to time, there may be a need to modify the terms of this agreement and that copies of updated Privacy Statements will be located in the upstairs waiting room and at Reception downstairs of the Practice and that any responsibility to keep myself updated as to relevant changes rests with myself whether as a patient, parent or guardian.

I understand that a copy of this agreement will be included in my medical notes and that a copy has been provided to me today for reference.

Queries or complaints regarding Privacy? Please write to Ms. Sashi Naidu. A written response will be provided within 6 weeks of receipt.

Patient name: (Please Print) _____

Signature (of patient/parent/guardian): _____ Date: _____

Witnessed by: (Staff member signature) _____