Confidential Patient Details

The doctors and staff of **Gilles Plains Medical Centre** extend a warm welcome to you as a new patient. We are committed to providing our patients with the best care. To do this it is essential that your health record is kept up to date and accurate. When you make your first appointment our practice staff will collect your personal and demographic information via your registration.

It is Gilles Plains Medical Centre's Policy that Drugs of Dependence will NOT be prescribed to new patients. Drugs of Dependence medications include Opioids, Benzodiazepines and Stimulants.

Do you intend to use the practice for ongoing care? □ **Yes** □ **No**

Title:	Mr Mrs Ms. Dr. Miss Master Other Gender: Male Female
Given Name(s):	
Surname:	
Date of Birth:	
Home Address:	
Postal (if different):	
Phone:- Home	
Phone:- Mobile	
Email Address:	
Occupation:	
Medicare Number:	_ _ _ _ _ _ _ _ _ _ Ref No: _ Expiry Date: _ _ / _ _
DVA - Gold/White:	_ _ _ _ _ _ _ _ _ _ Expiry Date: _ _ / _ _ / _ _
Commonwealth Pension/Seniors:	_ _ _ _ _ _ _ _ _ Expiry Date: _ _ / _ _ / _ _
Health Care Card:	_ _ _ _ _ _ _ _ _ _ Expiry Date: _ _ / _ _ / _ _
Private Health Cover	Fund Name: Membership No: Hospital/Extras (Please circle)
Next of Kin:	Name: Relationship: Phone:

Emergency Contact:	Name: Relationship:	Phone:
Country of Birth:		
Ethnicity? (family origins)		
Do you identify as Aboriginal and/or Torres Strait Islander?	□ Yes	□ No
Do you have Ambulance Cover?	□ Yes	□ No
How did you hear of our Practice?		
Family Members attending Gilles Plains Medical Centre	1) 2) 3) 4)	
Are you registered for My Health Record ?	□ Yes	□ No
Are you an Organ Donor ?	□ Yes	□ No
Do you have Advance Care Directive?	□ Yes	□ No

FOR CHILD (Under 16 years of age) *NB: All Children will ONLY be bulk billed until their 16th Birthday (unless on a Concession Card)*

Parent's

Name.....**Surname**.....

DOB:.....**Best Contact**

Number:.....

Medicare reference number:.....(number in front of your name on Medicare card)

New Patient Health Details

**** If you intend to use our Practice again Please complete and hand to the DOCTOR***

MEDICAL HISTORY

Allergies □ Yes □ No

Please list allergies	**Reaction**

Smoking

Are you a non smoker? □ Ex-smoker? □ Smoker? □ If yes, how many _____per day

Drug use: □ Yes □ No If yes, _____(type and frequency)

Alcohol

Non Drinker? □

Current alcohol Intake- days_____ per week; Standard drinks_____ per day?

Significant Family History:

Mother: □ Diabetes □ Hypertension □ Heart Disease □ Stroke
□ Colon Cancer □ Depression □ Breast Cancer □ Other

Father: □ Diabetes □ Hypertension □ Heart Disease □ Stroke
□ Colon Cancer □ Depression □ Other

Medical conditions – Patient (past or current)

□ Asthma □ Diabetes □ Hypertension (High Blood Pressure) □ Mental Health Problems

□ Operations/surgical procedures □ Other _____

Have you had any Care Plan done within the last 12 months?

□ Yes □ No _____

Current medications (including over the counter medications, vitamins & minerals):

Immunisations

Childhood immunisations □ Yes □ No

Influenza Year _____ □ not sure □ never

Pneumococcal pneumonia (over 65) Year _____ □ not sure □ never

Gilles Plains Medical Centre

Shop 33 & 35, 575 North East Road, Gilles Plains SA 5086

PATIENT CONSENT & PRIVACY IS THE CONCERN OF OUR PRACTICE

The doctors at Gilles Plains Medical Centre aim to provide patients with high quality continuing care combined with respect for their privacy. Our practice requires a confidentiality statement from doctors, allied health professionals, nursing and administrative staff.

We comply with privacy legislation and maintain patient confidentiality. We need your consent to collect personal information about you. It is important to explain to whom we may disclose this and how and why this disclosure would happen.

Typical situations that may require disclosure are:

- **the diagnosis and treatment of your problem**, including communication with practice staff, specialists and other health care providers involved in treating you.
- **the provision of preventative medicine.**
- **our practice administration, accreditation and quality assurance.**
- **billing and collection of professional fees.**
- **teaching, education and medical research** (information released for non-professional purposes does not contain patient identification. If you do not want your records accessed for this purpose we will note your record accordingly).
- **emergency and after hours contact and change of appointment times.**
- **disclosure to approved other persons for medico-legal purposes if necessary** and authorised by your doctor.

Do you consent to us sending the following types of communications to you from time to time, **via SMS?**

- **appointment reminders** – notifications to you to remind you of upcoming appointment dates with the practice as well as allowing you to confirm your appointment; **Yes ☐ No ☐**
- **clinical reminders**-notifications to you to remind you to contact the practice to arrange appointments for regular clinical check-ups, medical procedures, immunisations due; **Yes ☐ No ☐**
- **clinical communications** - communications to you about your clinical care at the practice such as returned pathology results or clinical messages from the medical practitioner; **Yes ☐ No ☐**
- **health awareness** – communications to you in relation to general health care information and health care services provided by this general practice including notification about changes to our clinic opening hours, and information about health care services provided by this general practice. **Yes ☐ No ☐**

****Please note that we do not send "junk mail".**

As part of the provision of health care services to you, we will send you appointment reminders, clinical reminders and clinical communications from time to time. We may also send you health awareness information if you have consented to receive such communications below. We may use third party service providers (which may be located outside of this State or Territory) and disclose your personal information (including health information) to them, to assist us in sending you the above communications.

To the extent practicable, we will send you communications via your preferred contact method indicated below. However, you acknowledge that we may contact you using any of your contact details that you may provide to us from time to time, as we consider appropriate.

My preferred contact method for **all** communications is:

Phone ☐ Letter ☐ SMS ☐ App ☐ Email ☐

You may nominate any person/s to whom you are comfortable for us to release information such as prescriptions, test results, specialist appointments and referrals.

I nominate (Please tick) to receive information about my health

- Anybody who answers my home phone or answering machine ….....
- The following people: ….....
  ……..
- Me only: ….....
- Special requests: ….....

In any specific situation, you may ask us not to release information, and of course that request will override your nominations.

I have read this form and understand why collecting information about me (or my child) is necessary.
I confirm that the information I have given (on this form) is correct. I consent to sharing of all relevant information between the general practitioners, specialists, nurse practitioners, nurses, allied health providers and non-clinical staff for the purpose of managing my health. I understand this information will be used to fulfil their duties in the course of planning and managing my health care.
I consent to the handling of my information by this practice in the ways and for the purposes set out above.

Full Name : ….....…

Patient name (if under 16): ……..……..

Signature : ….....….....

Patient's Date of Birth: …...../...../..... Date: ……

Please feel free to talk to your doctor or our staff should you need any clarification.

CANCELLATION POLICY

Cancellation of appointments:

If you need to cancel or change your appointment, we require at least 4 hours notice.
Failure to give adequate notice will incur a non-attendance fee at the discretion of your doctor.

Unless otherwise negotiated, I understand the above fees will be applied if I do not give adequate warning of a cancellation. I acknowledge that I am personally responsible for the payment of my account.

I have read and understood the Cancellation Policy of this practice, and understand the terms outlined above.

Signature(s):_____Date: _____