



NEW PATIENT INFORMATION FORM

We are committed to providing our patients with the best care, to do this it is essential that your medical records are up to date and accurate.

Title _____ Surname _____ Given Names _____

Preferred Name _____

Date of Birth _____ Gender _____ Pronouns _____

Marital Status _____

Home Address _____

Mailing Address _____

Occupation _____

Home Phone _____ Work Phone _____

Mobile Phone _____ Consent for SMS Yes/No _____

Email Address _____

Medicare Card Number _____

Medicare Card Ref Number _____ Medicare Card Expiry Date _____

Pension, Health Care Card or DVA Number _____

Type of Veterans Affairs Card _____ Expiry Date _____

Private Health Cover Name _____ Number _____

(Cover Included Hospital, Extra, Ambulance) _____

Next Of Kin _____

(Name, Phone No, Relationship)

Emergency Contact _____

(Name, Phone No, Relationship)

Ethnicity – eg Australian non indigenous, First Nations/Indigenous, Other (please specify)

Do you require an Interpreter? If Yes which language? _____

Health History – Do you have/had (Asthma, Diabetes, Hypertension, Chronic Illness)



Family Health History eg Mother alive? If not age of death/cause

Family Health History eg Father alive? If not age of death/cause

Do you have any allergies? If Yes please specify (include what happens when you have the allergen, eg rash, anaphylaxis) _____

Are you a Smoker Yes/No _____ How many _____ Per Day / Week / Month

Alcohol Use Yes/No _____ How many _____ Per Day / Week / Month

Cervical Screening _____

Weight (if known) _____ Height (if known) _____

CONSENT

Upon consent Thrive Family Practice may access my medical file and personal details for doctors and practice staff to converse with other doctors, specialists and their staff other allied health care providers and pharmacists who are directly involved in my care for home medication reviews or case conferences.

Periodically, our doctors and nurses will arrange a Case Conference so that all practitioners can come together and discuss and plan your care as a team. You do not need to be present for this, but you will be provided with a written summary of the meeting and will be able to discuss this with your nurse or doctor.

Do you agree to this: Yes/No Initial _____

Our practice uses a reminder system to help you maintain your health. The practice sends reminders by SMS, telephone or post for procedures, vaccinations, cervical screening and other health reviews, results, and clinical communications.

Do you agree to this: Yes/No Initial _____

I understand that the practice participates in National and State recall programs such as but not limited to Breast Screen SA, Cervical Screening, Immunisation Programs, National Bowel Screening

Do you agree to this: Yes/No Initial _____

I consent to being contacted with reminders to help me maintain my health

Do you agree to this: Yes/No Initial _____

I understand that the practice participates in the My Health Record scheme and my doctor may view, upload and/or download health information from this system as required

Do you agree to this: Yes/No Initial _____

Our practice may use an AI medical scribe called Lyrebird to help create notes from your consult. Lyrebird listens to the consultation and transcribes in real-time. Once the notes are completed, all audio files are securely destroyed.

Do you agree to this: Yes/No Initial _____

Name _____

Signature _____ Date _____