appletree family practice

Admin to complete

Admin details added to file

Date: _____

Signature: _____

New Patient Form

We are committed to providing you with the best care. Please help us to keep your health record up to date and accurate.

Title:	Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master ☐ Other ☐
Birth Sex:	Male ☐ Female ☐
Gender:	Male ☐ Female ☐ Non-binary ☐ Gender Diverse ☐ Transgender ☐ Different Identity ☐
Surname:	
First Name:	Middle Initial:
Preferred Name:	Date of Birth: / /
Street Address:	
Postal Address (if different to street address)	
Mobile Ph:	Work Ph: Home Ph:
Medicare Number:	IRN: Expiry: / /
Private Health Pension/HCC No: Please tick card type:	Health Fund: Membership No: Expiry: / / Pension Concession Card ☐ Health Care Card ☐ Commonwealth Seniors Card ☐
DVA No and Colour	Gold ☐ White ☐ Lilac ☐ Orange ☐
Occupation:	Ethnicity:
Head of Family: (persons under 17)	Self ☐ OR Name: Relationship : Phone:
Next of Kin	Name: Relationship: Phone:
Emergency Contact	Tick if same as Next of Kin ☐ OR: Name: Relationship Phone:
Email address	

Do you require an interpreter? Yes ☐ No ☐ If so, what language? _____

To assist with health initiatives – do you identify as Aboriginal or Torres Strait Islander?

☐ Yes - Aboriginal ☐ Yes - Torres Strait Islander ☐ No

Name: _____ **D.O.B:** _____

Medical history: Do you have any of the following conditions/diseases?

☐ Asthma	☐ Hepatitis	☐ Thyroid conditions
☐ Emphysema/COPD	☐ Peptic Ulcer	☐ Diabetes/Gestational Diabetes
☐ Tuberculosis	☐ Gout	☐ Cancer of any type
☐ Heart Disease/Heart Attack	☐ Osteoporosis	☐ Anaemia
☐ Stroke	☐ Dermatitis/Eczema	☐ Abnormal pap smear
☐ High Blood Pressure	☐ Psoriasis	☐ Anxiety
☐ High Cholesterol	☐ Dementia	☐ Depression
☐ Glaucoma	☐ Migraines	☐ Schizophrenia
☐ Blood Clots	☐ Seizures/Fits	☐ Bipolar

Any other condition not listed above:

_____

Please list any regular prescribed medications

_____

_____

_____

Please list any over the counter medications (this includes vitamins, minerals, herbal remedies)_____

_____

_____

_____

Do you have any medication/food/dressing allergies? ☐ Yes (please list below) ☐ No

Medication/food/dressing **Side effect/allergic response**

_____ _____

_____ _____

Women only:

Date of last Cervical Screening _____/_____ **Result:** Normal OR Abnormal (please circle)

Immunisation – have you had any of the following immunisations?

Tetanus Booster	Date: _____	☐ Don't Know	☐ Haven't had one
Hepatitis A	Date: _____	☐ Don't Know	☐ Haven't had one
Hepatitis B	Date: _____	☐ Don't Know	☐ Haven't had one
Pneumococcal	Date: _____	☐ Don't Know	☐ Haven't had one
Influenza	Date: _____	☐ Don't Know	☐ Haven't had one
Polio	Date: _____	☐ Don't Know	☐ Haven't had one
MMR	Date: _____	☐ Don't Know	☐ Haven't had one
Typhoid	Date: _____	☐ Don't Know	☐ Haven't had one
Rabies	Date: _____	☐ Don't Know	☐ Haven't had one
Chickenpox	Date: _____	☐ Don't Know	☐ Haven't had one
Meningococcal B	Date: _____	☐ Don't Know	☐ Haven't had one

Child Immunisation – If completing for a child, are their immunisations up to date?

Yes ☐ No ☐

Family history:

Have any members of your family been diagnosed with or suffered from (please list person's relationship to you):

☐ Diabetes: _____
☐ Asthma: _____
☐ Heart Disease: _____
☐ Mental Illness: _____
☐ Cancer: _____
Other Conditions: _____

Social History:

☐ Tobacco: I have never smoked
☐ Tobacco: Ceased smoking: ____/____/_____ OR I smoke _____ cigarettes per day/week

☐ Alcohol: I do not drink alcohol
☐ Alcohol: I consume _____ drinks per day, _____days per week
☐ Alcohol: I consume _____ drinks per week/month
☐ Alcohol: How often would you drink more than 6 drinks per day? _____

Height: _____cm **Weight: _____**kg **Waist Measurement:** _____cm

How often do you exercise OR engage in physical activity for 30 minutes or more?

☐ Daily ☐ _____ times per week ☐ Never ☐ Other _____

Social/Family Structure:

Marital status

☐ Married ☐ Defacto ☐ Single ☐ Widowed No. of children: _____

Who lives at home with you? _____

Are you a carer for someone? ☐ Yes ☐ No *OR* Is someone a carer for you? ☐ Yes ☐ No

Consent

Our surgery requires the above information to maintain your records electronically. This form will be scanned into your patient file and securely stored. I give permission for my personal health information to be used for administrative purposes to assist in the running of this practice, this includes disclosure to others involved in your healthcare, such as treating Doctors within and outside this medical practice. This may occur through referral to other Doctors, or for medical tests and in the reports or results returned to my doctor following referrals.

Signature: _____ **Date**: _____

Communication/ Reminder Consent Form

SMS Reminders and Notifications

I consent to the practice contacting me by text message for the purpose of health promotion, practice news, appointment reminders, and to advice of Doctors running behind schedule and any follow-ups if required.

I acknowledge that appointment reminders and follow- up reminders by text are an additional service and that they may not be sent on all occasions and that the responsibility for attending appointments, cancelling them and calling for results still rests with me.

I understand I can cancel the text message facility at any time.

Text messages are generated using a secure facility and I understand that they are transmitted over a public network onto a personal telephone and as such may not be secure. However, the practice will not transmit any information which would enable an individual patient to be identified e.g. only first names will be used.

Email Reminders

I consent to the practice contacting me by email for the purpose of health promotion, health reminders, practice news and general follow ups for preventative care.

Emails are generated using a secure facility but I understand that they are transmitted over the internet and as such may not be secured. However, the practice will not transmit any information which would enable an individual patient to be identified. I understand I can cancel the email facility at any time.I understand that any SMS text message and email I forward to the practice are transmitted over public phone networks and the internet and may be intercepted and not reached the practice.

Personal Information

This information will be scanned into your health record. Personal information retained in your file is stored in a secure data area and treated as highly confidential.

Patient full name		Date of Birth	
Address			
Mobile Phone Number			
Email Address			

I have read the information both the Email and SMS Reminders/Notifications consent form and agree to the terms and conditions listed on page one. I give permission to be contacted by SMS and email.

Signature: _____ Date: _____

Consent to Participate in Register, Recall and Reminder Systems

Consent for Appletree Family Practice to send appointment reminders, result recalls and preventative health reminder through our online reminder system HOTDOCS.

By NOT completing the consent process below, the patient acknowledges and accepts full responsibility for pro-actively following up on all reminders and recall notifications.

☐ I _____ give my consent to participate in Practice, State and

National Register, Recall and Reminder programs.

I understand that I can have my name removed from this register at any time.

OR:

☐ I _____guardian/representative of

_____give my consent for them to participate in Practice, State and National Register, Recall AND Reminder programs.

I understand that this practice will contact me (the patient or my representative) to advise results and preventative care activities.

I understand that I can have the patients name removed from this register at any time.

Please tick the applicable box and sign the consent form.

Signature: _____

Print Name: _____

Date of Birth: _____

Relationship (if applicable):_____

For Women re: PAP Smears/CST

Consent for Appletree Family Practice to receive previous pap smear results

☐ I_____ give my consent for Appletree Family Practice to receive my previous pap smear/CST results from the National Cancer Screening Register.

OR:

☐ I _____ don't give my consent for Appletree Family Practice to receive my previous pap smear/CST results from the National Cancer Screening Register.

Please tick the applicable box and sign the consent form.

Signature: _____

Print Name: _____

Date of Birth: _____

Relationship (if applicable): _____