Seymour Medical Clinic
'Healthy Country Life'

3275 05044 6 **Health Information – Collection and Use Consent Form**

Seymour Medical Clinic requires your consent to collect personal information about you. All persons accessing your health information are bound by confidentiality. This practice collects such information for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history to allow us to properly assess, diagnose, treat and advise on all your health care needs. Information may be used in the following ways:

- Administrative purposes to assist in the running of Seymour Medical Clinic, including the disclosure to others involved in your healthcare, such as treating doctors and specialists within and outside of the Clinic. This may occur through referral to other doctors, or for medical test and in the reports or results returned to the doctor following referrals.

- Billing purposes, including electronic billing through Medicare or Veteran's Affairs.

- Quality assurance and research activities using de-identified information to improve health care and practice management.

- To comply with any legislative or regulatory requirements, such as notifiable disease.

Please tick the following boxes and sign the form to indicate your consent.

 I consent to the handling of my information by the Clinic for the purposes set out above. Further disclosure will not occur without my consent. I am aware of my rights to access the information collected about me, except in some situations where access may be legitimately withheld. I will be given an explanation in such circumstances. I am free to withdraw my consent at any time.

 I agree to receive SMS appointment reminder messages

 I agree to receive health care reminder messages by mail or phone from time to time.

OR

 I am unsure and would like to discuss this form with someone from the clinic before I sign.

Patient's Name_____
Patient's Signature_____Date_____
Signed as Guardian for child_____Name printed_____

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New Patient Information Form

Section 1

If Patient is under 16 years	Name of Parent or Guardian		Date of Birth / /
Medicare		Your number on card (next to your name)	Exp /

Patient Surname		Previous Surname (if any)	
Given Name/s		Preferred Name (if any)	
Preferred Title	Gender : Male / Female / Other	Date of Birth / /	Marital Status
Street Address		Town	Postcode
Postal Address		Town	Postcode
Home Phone		Work	Mobile
Email Address			
Medicare		Your number on card (next to your name)	Exp /
Pension/HCC	- -	Expiry Date / /	
DVA #		Gold card White card	Exp / /
Cultural background			
Emergency Contact	Name	Phone	Relationship
Next of Kin	Name	Phone	Relationship
Do you wish to identify as	Aboriginal Y N	Torres Strait Islander Y N	Aboriginal & Torres Strait Islander Y N
Do you wish to identify as	A person with a culturally and / linguistically diverse background? If yes please tell us.		
Is a translator required for your consultation? No Yes			
Do you have any allergies or are you sensitive to drugs or dressings? No Yes Please elaborate			

TRANSFER OF HEALTH INFORMATION:

You may have regularly consulted with a GP at another practice and the health information held by that GP may assist us with your future health care needs. If you wish to have a summary of your health records, including your most recent test results, transferred to this practice our receptionist can assist you to arrange the transfer.

- **Please hand section 1 of this form to the receptionist .**
- **Section 2 is optional.**
- **If you choose to complete section 2 you can give to the receptionist - or to the Dr if you prefer.**

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Please sign and date this form……Date……

New Patient Information Form

Section 2 / Page 1 of 2

We invite you to answer the following questions which will help to create your personal health file. However, these questions are optional and if you prefer only to discuss any of these topic directly with you doctor, we respect your choice. You can fill out some questions, all the questions, or no questions at all.

Patient's Name……..

Occupation……..

Your health history – do you have, or have you a history of:

- ☐ Operations _____
- ☐ Asthma _____
- ☐ Diabetes _____
- ☐ Hypertension _____
- ☐ Chronic illness _____
- ☐ Other _____

Immunisations – have you had the following immunisations?

Tetanus booster	**Date**	**☐ Don't know**	**☐ Have not had one**
Hepatitis B	**Date**	**☐ Don't know**	**☐ Have not had one**
Hepatitis A	**Date**	**☐ Don't know**	**☐ Have not had one**
Influenza	**Date**	**☐ Don't know**	**☐ Have not had one**
Pneumococcal	**Date**	**☐ Don't know**	**☐ Have not had one**
Polio	**Date**	**☐ Don't know**	**☐ Have not had one**

If completing this form for a child…are the childhood immunisations up to date? ☐ Yes ☐ No ☐ Don't know

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

_____

_____

☐ Tobacco _____day /week or …… ceased smoking ☐ date_____

☐ Alcohol drinks per day_____ or week_____or month_____

☐ Drug use_____

☐ Exercise_____

New Patient Information Form

Patient's Name…….
Family history – have any members of your immediate family (blood relatives) had:

☐ Asthma
_____

☐ Diabetes
_____

☐ Heart disease
_____

☐ Chronic Illness
_____

☐ Other
_____

Height_____cms Weight_____kgs

Blood pressure – when was the last time your blood pressure was taken?_____

Sun Protection: How often do you use the following to protect you from the sun when outdoors?

	Always	Often	Sometimes	Rarely	Never
Protective clothing	☐	☐	☐	☐	☐
Sunscreen creams	☐	☐	☐	☐	☐

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

Males: when did you last have:

An overall check up	Date	☐ Not sure	☐ Never

Are there any health issues about which you would like more information?

Thank you very much for taking time to work through these questions. Please do not hesitate to speak with our staff if you have a question or comments about this form or any part of the service.