Tristar Medical Group

NEW PATIENT INFORMATION

Please Circle:	Miss / Ms / Mrs / Mr / Master / Dr /.....	**SEX: MALE/FEMALE** *(Please Circle)*	
Given Names:			
SURNAME :	**Date of Birth:** ..... /..... /.....		
Postal Address:			
Suburb/Town:		**Post Code:**	
Telephone:	H: ..... W: ..... M:		
Email Address:			
Do you identify as being Aboriginal or **Yes/No** *(Please Circle)* **Torres Strait Islander?** **Yes/No** *(Please Circle)*		**Occupation**	
Country of Birth:		**Ethnicity:**	
Medicare & Reference No. *(number next to Name on Card)*	**(Medicare No.)** __ __ __ __ - __ __ __ __ __ - __ **(Ref No.)** __ Expiry..... /.....		
Pension/DVA/Health Care Card: *(Please circle)*	**(Card No.)** __ __ __ - __ __ __ - __ __ __ __ **Expiry**..... /..... /.....		

Next of Kin Contact Details: **Relationship to Patient:** ..... **Name:** ..... **DOB:** ..... **Address:** ..... **Contact Number(s):**	**Emergency Contact Details:** **Relationship to Patient:** ..... **Name:** ..... **DOB:** ..... **Address:** ..... **Contact Number(s):** .....

ADF Service

- ☐ **Never Served**
- ☐ **Current Australian Defence Force – Permanent Member**
- ☐ **Current Australian Defence Force – Reserves**
- ☐ **Past Australian Defence Force – Permanent OR Reserves**
- ☐ **Unknown**

How did you hear about Tristar? PLEASE TICK

- ☐ **Telephone Book**
- ☐ **Internet**
- ☐ **Online**
- ☐ **Pages Yellow/White**
- ☐ **Signage**
- ☐ **Family Member**
- ☐ **Word of Mouth**
- ☐ **Other Please Specify**

Practice Policy and Patient Consent:

Our practice has a policy for clinical handover to another practitioner within the clinic during periods where your normal treating Doctor is absent in order to manage follow up care. Our practice has a policy for "Failure to attend". A patient is considered to be a "Failure to Attend" when they have failed to attend the practice for an appointment and do not notify reception staff at least 2 hours prior that they will not be able to attend their appointment. Patients who do not attend their appointment may be subject to a fee.

I have read the above practice policy: ☐ **Yes**

I consent to the information provided above to be used to contact me when necessary and that my personal health information may be used for statistical purposes

Patient's Signature..... **Date:** ..... /..... /.....

Parent/Guardian's Signature (if patient is under the age of 18) ..... **Date:** ..... /..... /.....

Will this clinic provide you with the majority of care over the next 12 months? **Yes/No** *(Please Circle)*
Are you visiting the area? **Yes/No** *(Please Circle)*

Translator required? *Ph: 13 14 50 (telephone assisted service)*	**Yes/No** *(Please Circle)* Language/s: .....

MEDICAL HISTORY – NEW PATIENTS

Your health history – do you have or have you had a history of?

☐ Operations_____
☐ Asthma_____
☐ Diabetes _____
☐ Heart Disease _____
☐ High Blood Pressure _____
☐ Mental Illness _____
☐ Cancer _____
☐ Muscular/skeletal (arthritis/muscle/joint pain)

_____
☐ Other_____

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

_____
_____
_____

Social History

☐ Tobacco _____ day/week or cease smoking – date _____
☐ Alcohol _____ day / week / month (circle the one applicable)
☐ Drug use _____(type and frequency)

Do you have any allergies or are you sensitive to drugs or dressings:

☐ Yes ☐ No

_____
_____

Blood Pressure: when was the last time your blood pressure was taken?

_____

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

Tristar Medical Group

Tristar Medical Group requires your consent to collect personal information about you. Please read this consent form carefully, tick the applicable boxes and sign where indicated below.

Tristar Medical Group 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. Please place a tick in the following boxes if you give consent for this information to be used by Tristar Medical Group in the following ways:

☐ I give my permission for my personal health information to be used for administrative purposes to assist in the running of Tristar Medical Group, including disclosure to others involved in my healthcare, such as treating doctors and specialists within and outside Tristar Medical Group. This may occur through referral to other Doctors, or for medical tests and in the reports or results returned to my doctor following referrals.

☐ I give my consent for disclosure for research and quality assurance activities to improve individual, community health care and Practice management. This may occur when Tristar Medical Group incorporates patient health records into de-identifiable patient information to transfer to a third party, normally used for quality improvement projects. De-identifiable patient information cannot be traced back to the individual.

☐ I give my consent for my personal health records to be used for identifiable patient health information. This may occur when Tristar Medical Group participates in research activities on behalf of a university as part of professional development activities to be collected. Identifiable patient information can possibly be traced back to the individual.

☐ I give my consent to the presence of a third party to be present during my consultation. This may include a Practice Nurse or medical student.

☐ I give my consent to be part of the Practice's National, State and Territory recall and reminder systems.

I understand by ticking the relevant boxes above that Tristar Medical Group is authorised on my behalf to use my relevant personal health information and I am free to withdraw my consent at any one time by verbal or written notification.

(To be completed if patient does not speak English): I (name)……translated the above information to (name of patient)…… and they have signed below. (Name of patient)……understands Tristar Medical Group is authorised on their behalf to use their relevant personal information and they are free to withdraw their consent at any one time by verbal or written notification.

Print name of Patient: ……

Signature of Patient: ……

Print name and signature of Parent /Guardian (if under 18): ……

Date: ……