central WAGGA MEDICAL & SKIN CLINIC

NEW PATIENT INFORMATION		**Date:**
Title:	Surname:	First Name:
Preferred Name:	DOB: / /	Occupation:
Street Address:		Suburb:
Postcode:	Mobile:	Home Phone:
Work Phone:	Email Address:	
Do you identify as Aboriginal/Torres Strait Islander: **Ethnicity:**		

Medicare Number:		Reference Number:
Expiry:	DVA Number:	Expiry:
Pension Card:		Expiry:
Next of Kin		Relationship:
Mobile:	Home Phone:	Work Phone:

Name Parent/Guardian (Under 18):	**DOB:**
Street Address:	**Post Code:**
Medicare Number:	**Reference:**
Main Reason you decided to book with us: Please circle Word of Mouth Facebook Google Other:Please Specify	

COLLECTION OF PERSONAL INFORMATION, PRIVACY ACT 1988 We require your consent to collect personal information about you. Please read this information carefully, and sign where indicated below. This medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose and treat illnesses and be proactive in your health care. We will also use the information you provide in the following ways:

- Administrative purposes in running our medical practice including billing purposes, and compliance with Medicare and Health Insurance Commission requirements
- Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals. If necessary, we will discuss this with you.
- Disclosure to other doctors in the practice, locums and by Registrars attached to the practice for the purpose of patient care and teaching. Please let us know if you do not want your records accessed for these purposes, and we will note your record accordingly.
- Disclosure for research and quality assurance activities to improve individual and community health care and practice management. You will be informed when such activities are being conducted and given the opportunity to "opt out" of any involvement. This includes uploads of Health Summaries and Health Events to your eHealth record.
- Sharing of referrals, care plans and or medical information to relevant parties can occur via fax or email.

I have read the information above and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling patient information. I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to me. I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances. I understand that if I request access to information about me, the practice will be entitled to charge me fees to cover time spent by administrative staff to provide access at the employee's hourly rate of pay, time necessarily spent by a medical practitioner to provide access at the practitioner's ordinary sessional rate and for photocopying and other disbursements at cost
I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained. I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure that I notify this practice. I consent to emails updating me on practice policies and services

Patient name: .....

Signed:.....Date:.....

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Patient Name: **DOB:**

Allergies/Intolerances		**Nil Known**
Current Medications:	**Strength:**	**Dose:**
Family History (Immediate Relatives): Please Circle Heart Disease Hypertension Inherited conditions: please specify Other: Breast Cancer: Bowel Cancer Stroke Diabetes		
Medical/Surgical History:		
Have you ever had a skin check: YES/NO		**Date of last skin check: / /**

Smoking History: Please Circle Never Smoked: Former Smoker: Quit Date: / / Current Smoker: /day Number of Years Smoking:	**Alcohol: Please Circle** Do you drink alcohol? YES/NO Drinks per day: Drinks per week:	**Exercise: Please Circle** Do you exercise regularly: YES/NO Per week: Per month: Type of exercise:
Are you interested in stopping smoking or drinking less: YES/NO		
Are you interested in receiving information about our skin care products and regimes: YES/NO		

WOMEN'S HEALTH
Date of Last Cervical Screen: / /
What would you like to achieve from your visit today?