

GAWLER MEDICAL CLINIC

New Patient Information Form



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

* FIRST NAME		* MS *MRS *MR *OTHER	
* SURNAME			
* DATE OF BIRTH			
* MEDICARE NUMBER	Ref No.	Expiry Date	
*DVA Gold / White (Please Circle)		Expiry Date	
* CONCESSION CARD e.g.: Pension/HCC/Seniors HCC	Ref No.	Expiry Date	
* PRIVATE HEALTH FUND: Name/number/level of cover			
* RESIDENTIAL ADDRESS		*SUBURB	
* POSTAL ADDRESS		*SUBURB	
* HOME PHONE	WORK PHONE	MOBILE	
EMAIL			
OCCUPATION			

NEXT OF KIN

EMERGENCY CONTACT

Same as Next of Kin Yes No

* NAME	* NAME
* RELATIONSHIP TO PATIENT	* RELATIONSHIP TO PATIENT
* ADDRESS	* ADDRESS
* PHONE NUMBER (H) (M)	* PHONE NUMBER (H) (M)

IN THE EVENT OF AN EMERGENCY, WHO WOULD BE YOUR FIRST CONTACT PERSON? Next of Kin Emergency Contact

DO YOU HAVE ANY ALLERGIES OR ARE YOU SENSITIVE TO ANY DRUGS OR DRESSINGS?

- No
 Yes. Please elaborate:

DO YOU REQUIRE AN INTERPRETER SERVICE?

Yes No

PLEASE SEE REVERSE



Australia is a genuinely multicultural society. To tailor appropriate care, encourage understanding and appreciation between people from different nationalities and backgrounds,

DO YOU IDENTIFY AS SOMEONE FROM A DIVERSE CULTURAL AND/OR LANGUAGE BACKGROUND?

- No
- Yes. Please elaborate: _____

TO ASSIST WITH HEALTH INITIATIVES- DO YOU IDENTIFY AS BEING OF ABORIGINAL OR TORRES STRAIT ISLANDER DESCENT?

- No
- Yes – Aboriginal
- Yes – Torres Strait Islander
- Yes – Aboriginal & Torres Strait Islander

IF YES, ARE YOU REGISTERED FOR THE CLOSING THE GAP PROGRAM? Yes No

REMINDER SYSTEM: Our practice provides our patients with preventive care and early case detection reminders e.g. immunisations, annual health check, skin check and pap smears.

DO YOU CONSENT TO HAVING YOUR HEALTH REMINDERS SENT TO YOU BY MAIL? Yes No

DO YOU CONSENT TO SMS CONTACT/REMINDERS FROM THE SURGERY? Yes No

SMOKER:

- No
- Yes. Number smoked per day _____ or ceased smoking date _____

SOCIAL HISTORY:

- Alcohol: _____ day / week / month (circle the applicable)
- Drug use: _____ type and frequency.

YOUR HEALTH HISTORY:

FAMILY MEDICAL HISTORY:

PLEASE DISCUSS WITH THE DOCTOR ANYTHING ELSE YOU MAY FEEL IS RELEVANT TO YOUR MEDICAL CARE

GENERAL INFORMATION

- All accounts must be paid in full on the day of consultation. Discounts apply for payment on the day of consult. EFTPOS facility is available. Medicare online facility is available at the surgery which allows your bank account to be credited in two working days if your bank details are held by Medicare or lodged at the time of paying your account.
- Medicare does not completely cover the cost of your consultation.
- Discounts do apply for aged pensioners, concession cardholders and children under 16 from Monday to Friday.
- The surgery does not routinely bulk bill Senior Card cardholders.
- If your Doctor bulk bills you for personal reasons it does not guarantee you that all Doctors will do the same.

Non-Attendance/Cancellation Policy

- Gawler Medical Clinic encourages patients to contact the clinic as soon as possible to cancel their appointment.
- Patients are also encouraged to participate in SMS reminders for their appointments to minimise non-attendance of appointments.
- A minimum 2 hour cancellation period will apply from 8.30am. (The clinic phones are answered from 8am).
- A non-attendance fee of \$65 will apply for a standard appointment less than 20 minutes with the Doctor or nurse.
- A non-attendance fee of \$104.50 will apply for longer appointments with the Doctor or nurse.
- Doctors are advised of non-attending patients and it is at the discretion of the Doctor if this policy is enforced.
- A non-attendance fee may be reviewed for patients in extenuating circumstances or experiencing financial hardship and need to be made in writing to the Practice Manager.

Respect

- Gawler Medical Clinic will not tolerate violence, physical or verbal aggression towards it's staff.
- Staff working in this practice have the right to work in a supportive and safe environment.
- Patients attending this practice have the right to be cared for in a safe environment.
- Anyone displaying this behaviour will be asked to leave and may be reported to the police.

I consent to:

- The release and communication of information between any other medical provider relating to my assessment and ongoing clinical management
- The disclosure of adverse outcomes to Medical Defence Organisations, insurers, medical experts or lawyers for medical indemnity purposes
- The release of information for billing purposes, including compliance with Medicare and Health Insurance Commission requirements
- E-mailing of my investigation results to my personal email address I have supplied to my Doctor

Please cross out anything you do not consent to.

Doctors and Nurses have mandatory obligations by law to report infectious diseases and child abuse.

I have read the information above and understand why information about me is collected and disclosed to other parties. I consent to any such collection and disclosure as is necessary, subject to any limitations on access or disclosure as decided by me.

Name: (please print)

Signed:..... Date:

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It would be appreciated if you could tell us why you chose Gawler Medical Clinic:

- Signage, where _____
- Advertising in local paper
- Other advertising, Please list _____
- Word of mouth

