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** ***MISS *MSTR * MS *MRS * MR *MX *OTHER** **PRONOUN: ☐ she/hers/her ☐ he/him/his ☐ them/they/theirs**
*** SURNAME**
*** DATE OF BIRTH** *** BIRTH SEX: ☐ Male ☐ Female ☐ Other (please specify)…….…….…….. ☐ Prefer not to say** *** YOUR DESCRIPTION OF GENDER? ☐ Male☐ Female ☐ Non Binary ☐ Other (specify) ……. ☐ Prefer not to say**
*** 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 / HEAD OF FAIMLY (IF PATIENT UNDER 17 YEARS) **EMERGENCY CONTAC T**
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)
*DOB OF PARENT (IF UNDER 17 YEARS FOR MEDICARE REBATE)	

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 INNITIATIVES- 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.

My preferred contact method for all communication is : Mail Yes No **SMS** Yes No

If consenting to SMS are you happy to receive by SMS:			
	Appointment Reminders	Yes	No
	Clinical Reminders	Yes	No
	Clinical Communications	Yes	No
	Health Awareness/Promotion	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.
- Please notify reception if this is a workcover claim. If you have no claim number you will need to pay the account in full.

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 8.15am).
- A non-attendance fee of $80 will apply for a standard appointment less than 20 minutes with the Doctor or nurse.
- A non-attendance fee of $130.00 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.

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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: ……

……

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

Please see reverse

Patient Electronic Communications Consent
For Practice Communications to comply with Privacy Laws

Please read this carefully prior to signing

The purpose of this form is to inform you and seek your consent to the use and disclosure of your personal information (including health information) in regards to our reminders and notifications systems within our practice.

This general practice is committed to providing our patients with quality health care. As part of our commitment, we have implemented technology solutions to enable communications with our patients via SMS.

In keeping with our obligations under Privacy Act 1988 (Cth) and Australian Privacy Principles and under State and Territory health records legislation, we wish to inform you of the purposes for which we may use your personal information and how we may use and disclose your personal information (including health information). Please refer to our privacy policy or privacy statement, available on our website or from staff, for more information generally on the management of personal information (including health information) by this general practice.

In addition to other communications we may send you from time to time, we may send you the following types of communications:

	SMS CONSENT	
1. ***appointment reminders*** *– notifications to you to remind you of upcoming appointment dates with the practice as well as allowing you to confirm your appointment;*	*YES*	*NO*
2. ***clinical reminders*** *- notifications to you to remind you to contact the practice to arrange appointments for regular clinical check-ups, medical procedures, immunisations due;*	*YES*	*NO*
3. ***clinical communications*** *- communications to you about your clinical care at the practice such as returned pathology results or clinical messages from the medical practitioner; and*	*YES*	*NO*
4. ***health awareness*** *– communications to you in relation to general health care information and health care services provided by this general practice including notification about changes to our clinic opening hours, and information about health care services provided by this general practice.*	*YES*	*NO*

As part of the provision of health care services to you, we will send you appointment reminders, clinical reminders and clinical communications from time to time. We may also send you health awareness information if you have consented to receive such communications. We may use third party service providers (which may be located outside of this State or Territory) and disclose your personal information (including health information) to them, to assist us in sending you the above communications.

To the extent practicable, we will send you communications via your preferred contact method indicated.. However, you acknowledge that we may contact you using any of your contact details that you may provide to us from time to time as we consider appropriate.

I acknowledge and agree that, in the course of providing health care services to me, the general practice may need to use and disclose my personal information (including any health information) as set out in this form.

I acknowledge that the practice will use contact details provided by me (as updated by me from time to time) to communicate with me. To the extent that the mobile number I have provided to this general practice is utilised by more than one patient, I understand and consent that all SMS and phone communications will be directed to that number.

Please complete and sign below if you understand and agree to the acknowledgements and consent set out above.

Patient Name: _____ DOB: _____

Parent/Guardian Name (if Patient is under 16) _____ Mobile: _____

Signature: _____ Date: _____