**Confidential Patient Details**

The doctors and staff of **Belair Medical** extend a warm welcome to you as a new patient.

We are committed to providing our patients with the best care. To do this it is essential that your health record is

kept up to date and accurate.

Do you intend to use the practice for ongoing care? □ Yes □ No

|  |  |
| --- | --- |
| **Title:** | Mr Mrs Ms Dr Miss Master Other **Gender:**  Male Female |
| **Given Name(s):** |  |
| **Surname:** |  |
| **Date of Birth:**   |  |
| **Home Address:** |  |
| **Postal (if different):** |  |
| **Phone:- Home** |  |
| **Phone:- Mobile** |  |
| **Email Address:** |  |
| **Occupation:** |  |
| **Medicare Number:** | \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ (10 Numbers) **Ref No: \_**  **Expiry Date:**  \_ \_ / \_ \_ |
| **DVA -** **Gold/White:** | \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ **Expiry Date:**  \_ \_ / \_ \_/ \_ \_ |
| **Commonwealth Pension/Seniors:** |  \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ **Expiry Date:**  \_ \_ / \_ \_ / \_ \_ |
| **Health Care Card:** | \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ **Expiry Date:**  \_ \_ / \_ \_/ \_ \_ |
| **Private Health Cover** | Fund Name: Membership No: Hospital/Extras (Please circle) |
| **Next of Kin:**  | Name: Relationship: Phone:  |
| **Emergency Contact:**  | Name: Relationship: Phone:  |
| **Country of Birth:** |  |
|  **Ethnicity? (Your family origins)** |  |
| **Do you have Ambulance Cover?** |  |
| **How did you hear of our Practice?** |  |

**Do you identify as Aboriginal and/or Torres Strait Islander?** □ Yes □ No

**Do you consent to SMS Reminders being sent to you?** □ Yes □ No

**Do you consent to being placed on our recall system, if required?** □ Yes □ No

**Recalls -** Please indicate if you would prefer to be contacted via: □ SMS □ Phone □ Mail

|  |
| --- |
|  **FOR CHILD** (Under 16 yrs of age) **Parent's Name**.........................................................**Surname**.................................................................................. **DOB:**........................................................................**Best Contact Number:**.......................................................... |

**New Patient Health Details**

***\* If you intend to use our Practice again Please complete and hand to the DOCTOR***

**Name:**  \_\_\_\_\_

**Country of Birth**: \_\_\_\_\_

**If Child; Mother’s name:.............................................. Father‘s name.................................................**

**Do you have any family members attending Belair Medical?**

□ Yes □ No If Yes, Name: \_\_\_

**Do you have any allergies/sensitivities? □ Yes □ No**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Smoking**

Are you a current smoker? □ Yes □ No If yes, how many \_\_\_\_\_\_\_\_\_\_\_ per day

Are you an ex-smoker? □ Yes □ No

Drug use: □ Yes □ No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (type and frequency)

**Alcohol**

Do you drink alcohol? □ Yes □ No If yes, amount \_\_\_\_\_\_\_\_\_\_\_\_\_ per week

**Family History –** Have any members of your family had any of the following: diabetes, asthma,

heart disease, mental illness, cancer? (please state which family member)

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** \_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medical conditions (past or current)**

□ Asthma □ Diabetes □ Hypertension (High Blood Pressure) □ Mental Health Problems

□ Operations/surgical procedures □ Other \_\_\_\_

**Have you had a Care Plan done within the last 12 months?**  □ Yes □ No

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

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** \_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** \_\_\_\_\_ **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** \_\_\_\_\_

**Immunisations**

Children’s immunisations □ Yes □ No □ Parents declined immunisations

65 years and older

 Influenza Year\_\_\_\_\_\_\_\_\_\_\_\_\_ □ not sure □ never

 Pneumococcal pneumonia Year\_\_\_\_\_\_\_\_\_\_\_\_\_ □ not sure □ never

**Our Practice supports the “My Health Record“ – Are you Registered? If not can we register you today?** □ Yes □ No

 **Belair Medical**

**16 Main Road, Belair SA 5052**

**PATIENT CONSENT & PRIVACY IS THE CONCERN OF OUR PRACTICE**

**The doctors at Belair Medical Clinic aim to provide patients with high quality continuing care combined with respect for their privacy. Our practice requires a confidentiality statement from doctors, allied health professionals, nursing and administrative staff.**

**We comply with privacy legislation and maintain patient confidentiality. We need your consent to collect personal information about you. It is important to explain to whom we may disclose this and how and why this disclosure would happen.**

**Typical situations that may require disclosure are:**

* **the diagnosis and treatment of your problem, including communication with practice staff, specialists and other health care providers involved in treating you.**
* **the provision of preventative medicine.**
* **our practice administration, accreditation and quality assurance.**
* **billing and collection of professional fees.**
* **teaching, education and medical research (information released for non-professional purposes does not contain patient identification. If you do not want your records accessed for this purpose we will note your record accordingly).**
* **Our “patient recall” system.**
* **emergency and after hours contact and change of appointment times.**
* **disclosure to approved other persons for medico-legal purposes if necessary and authorised by your doctor.**

**You may nominate any person/s to whom you are comfortable for us to release information such as prescriptions, test results, specialist appointments and referrals.**

**I have read this form and understand why collecting information about me is necessary. I consent to the handling of my information by this practice in the ways and for the purposes set out above.**

**I nominate (Please tick) to receive information about my health**

* **Anybody who answers my home phone or answering machine ….........................**
* **The following people: …...............................................................................................**
* **Myself in person only: …..............................................................................................**
* **Special requests : …....................................................................................................**

**In any specific situation, you may ask us not the release information, and of course that request will override your nominations.**

**Full Name : …....................................................................................**

**Signature : ….....................................…............................................**

**Date of Birth: …......./............/............... Date: ……………………………**

**Please feel free to talk to your doctor or our staff should you need any clarification.**

**General Information**

**Our practice provides patients with preventive care and early case detection reminders.**

 **e.g.: - immunisations, annual health checks; skin checks and pap smears.**

**\*\*Please note that we do not send “junk mail”.**

**If you do NOT wish to receive such reminders, please advise our reception / nursing staff**.

**CANCELLATION POLICY**

**Cancellation of appointments:**

If you need to cancel or change your appointment, please try to give 4 hours minimum notice, otherwise you may be charged a non-attendance fee.

|  |  |
| --- | --- |
| **Booked Appointment Length** | **Non- Attendance Fee**  |
| **15 minute appointment****30 minute appointment** | **$37.00****$71.70** |

Unless otherwise negotiated, I understand the above fees will be applied if I do not give adequate warning of a cancellation. I acknowledge that I am personally responsible for the payment of my account.

I have read and understood the Cancellation Policy of this practice, and understand the terms outlined above.

Signature(s): …………………………………………………………………………….. Date: …………………..