Wallarah Bay Medical Centre
New Patient Information

Dear Patient. We are committed to providing our patients with the best care, to do this it is essential that your medical records are up to date and accurate. We Request the following information to complete your files. All information provided will be handled with utmost privacy and confidentiality and will only be used in the delivery of medical care to you.

Surname:	***Title*** Mr☐ Mrs ☐ Ms ☐ Miss ☐ Mast ☐ Other_____
Given name:	**DOB:** _ _ / _ _/ _ _ _ _
Country Of Birth:	**Ethnicity:** ☐ Australian ☐ Aboriginal ☐ Torres Strait Islander ☐ Other_____
Street Address	
Phone number	(h) (m) (w)
Email:	**Private health fund:**
Medicare/DVA Card	_ _ _ _ _ _ _ _ _ _ **Ref**_ **Exp** _____ /_____
Pension card ☐ Healthcare card ☐	_ _ _ _ _ _ _ _ _ _ **Exp** ___/___/_____
Next of kin	**Name:** **PH:** **Relationship:**
Emergency contact	**Name:** **PH:** **Relationship:**
Allergies: ☐Nil Known ☐Yes (please list):	
Medications: (please list)	
Employment Status ☐ Retired ☐ Unemployed ☐ Student ☐ Employed – Occupation _____	
Smoking	☐ Non Smoker ☐ Ex Smoker ☐ Current Smoker → Cigarettes per day ___
Drinking	☐ Non Drinker ☐ Occasional ☐ Yes - Days per week ___ Std drinks per day___
Marital status	☐ Single ☐ Married ☐ Defacto ☐ Separated ☐ Divorced ☐ Widowed
Living arrangements	☐ Own home ☐ Renting ☐ Aged care facility ☐ Hostel ☐ Other
Lives with	☐ Spouse ☐ Relative(s) ☐ Friend(s) ☐ Alone
Carer	**Do you have a Carer:** ☐ No ☐ Yes **Are you a Carer:** ☐ No ☐ Yes
Family history	☐ No significant family history ☐ Unknown
Mother	☐Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke ☐ Colon Cancer ☐Depression ☐ Breast Cancer ☐ Other_____ **Mother Alive:** ☐ Yes ☐ No – Cause of Death?_____ (if known)
Father	☐Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke ☐ Colon Cancer ☐Depression ☐ Other_____ **Father Alive:** ☐ Yes ☐ No Cause of Death?_____(if known)
My Health Records	My Health Record is a secure online summary of your health information. You can control what goes into it, and who is allowed to access it. You can choose to share your health information with your doctors, hospitals and other healthcare providers. Do you consent to register and to upload your my health record **Yes ☐ No ☐**

I (NAME OF PATIENT) _____ consent to this practice, transferring this information to other Health Providers for the purpose of my ongoing medical management , or for use in Practice Enhancement Activities (Information will be de-identified wherever possible when use for Practice Enhancement.

Communication I Consent to the practice to send SMS reminders, messages and emails to me, Please tick ☐ No if you do not consent.

SIGNATURE: _____ DATE:_____

FOR STAFF USE ONLY: ☐Medicare Card ☐Pension/Health Care Card ☐Drivers Licence/Photo Id ☐Staff Name_____

Wallarah Bay Medical Centre
New Patient Information

AUTOMED / Electronic Communication / Reminder Consent Form

AUTOMED: SMS Reminders and Notifications

I consent to the practice contacting me through AUTOMEDS secure online system via SMS text message for the purpose of appointment reminders, advising of Doctors running behind schedule and any follow-ups for results if required.

I acknowledge that reminders may not be sent on all occasions and that the responsibility for attending appointments, cancelling them and calling for results still rests with me. I understand I can cancel the text message facility at any time.

SMS text messages are generated using a secure facility through the AUTOMED app and I understand that they are transmitted over a public network onto a personal mobile telephone. The practice will not transmit any information, which would enable an individual patient to be identified. E.g., only first names will be used.

Email Communication

Patients are advised through the New Patient Information Sheet of the practice policy on electronic communication including:

- Seeking permission or consent from patients
- The possibility for electronic communications and information to be compromised.
- Notification of any costs involved.

I am aware that any communication I may direct to the surgery via email is NOT secure and confidentiality cannot be guaranteed.

I accept that communicating through email I am doing so at my own risk.

If I do contact the surgery via email this will be considered as my consent to reply via email.

I understand that I will not be emailed unless my email address has been verified by Wallarah Bay Medical Centre Doctors.

We endeavour to reply to all emails within 1 business day, however they are not constantly monitored.

If you have an issue that requires urgent attention we request that you contact the practice via telephone

Personal Information

Your personal information will be scanned into your health record. Personal information retained in your file is stored in a secure data area and treated as highly confidential.

Results Recalls System

I understand the practice will not contact me regarding results unless they are abnormal. The practice will inform you to make a non-urgent recall appointment to discuss any abnormal results through the AUTOMED app. If this is unsuccessful, a phone call followed by a posted letter will be attempted. For any URGENT results, a phone call will be made to make an appointment within one week.

Patient's full name:

_____

Date of birth:

_____

_____

I have read the above information about email and SMS text message appointment recalls and agree to the terms and conditions. I give permission to be contacted by SMS text message and email through AUTO MED system.

Signature: _____ **Date:**

_____

If applicable:

Guardian's full name: _____

Relationship:

_____

FOR STAFF USE ONLY: ☐Medicare Card ☐Pension/Health Care Card ☐Drivers Licence/Photo Id ☐Staff Name_____