



Wallarrah 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 <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Miss <input type="checkbox"/> Mast <input type="checkbox"/> Other _____	
Given name:		DOB: _ _ / _ _ / _ _ _ _	
Country Of Birth:		Ethnicity: <input type="checkbox"/> Australian <input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Other _____	
Street Address			
Phone number	(h)	(m)	(w)
Email:		Private health fund:	
Medicare/DVA Card	_ _ _ _ _ _ _ _ _ _		Ref _ Exp _ / _ / _
Pension card <input type="checkbox"/> Healthcare card <input type="checkbox"/>	_ _ _ _ _ _ _ _ _ _		Exp _ / _ / _
Next of kin	Name:	PH:	Relationship:
Emergency contact	Name:	PH:	Relationship:
Allergies: <input type="checkbox"/> Nil Known <input type="checkbox"/> Yes (please list):			
Medications: (please list)			
Employment Status <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Student <input type="checkbox"/> Employed – Occupation _____			
Smoking	<input type="checkbox"/> Non Smoker <input type="checkbox"/> Ex Smoker <input type="checkbox"/> Current Smoker → Cigarettes per day ____		
Drinking	<input type="checkbox"/> Non Drinker <input type="checkbox"/> Occasional <input type="checkbox"/> Yes - Days per week ____ Std drinks per day ____		
Marital status	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Defacto <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
Living arrangements	<input type="checkbox"/> Own home <input type="checkbox"/> Renting <input type="checkbox"/> Aged care facility <input type="checkbox"/> Hostel <input type="checkbox"/> Other		
Lives with	<input type="checkbox"/> Spouse <input type="checkbox"/> Relative(s) <input type="checkbox"/> Friend(s) <input type="checkbox"/> Alone		
Carer	Do you have a Carer: <input type="checkbox"/> No <input type="checkbox"/> Yes		Are you a Carer: <input type="checkbox"/> No <input type="checkbox"/> Yes
Family history	<input type="checkbox"/> No significant family history <input type="checkbox"/> Unknown		
Mother	<input type="checkbox"/> Diabetes <input type="checkbox"/> Hypertension <input type="checkbox"/> Heart Disease <input type="checkbox"/> Stroke <input type="checkbox"/> Colon Cancer <input type="checkbox"/> Depression <input type="checkbox"/> Breast Cancer <input type="checkbox"/> Other _____ Mother Alive: <input type="checkbox"/> Yes <input type="checkbox"/> No – Cause of Death? _____ (if known)		
Father	<input type="checkbox"/> Diabetes <input type="checkbox"/> Hypertension <input type="checkbox"/> Heart Disease <input type="checkbox"/> Stroke <input type="checkbox"/> Colon Cancer <input type="checkbox"/> Depression <input type="checkbox"/> Other _____ Father Alive: <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/>		
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 <input type="checkbox"/> No if you do not consent. SIGNATURE: _____ DATE: _____			



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HotDoc / Electronic Communication / Reminder Consent Form

HOTDOC: SMS Reminders and Notifications

I consent to the practice contacting me through HOTDOCS 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 HOTDOC 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 Wallarrah 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 HOTDOC 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 HOT DOCS system.

Signature: _____ **Date:** _____

If applicable:

Guardian's full name: _____

Relationship: _____