Admin to complete
Admin details added to file
Date: ___________________
Signature: ________________

New Patient Form

We are committed to providing you with the best care. Please help us to keep your health record up to date and accurate.

Title:	Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master ☐ Other ☐
Surname:	
First Name:	Middle Initial:
Preferred Name:	Date of Birth: / /
Street Address:	
Postal Address: (if different to street address)	
Email:	
Mobile Ph:	Work Ph: Home Ph:
Medicare Number:	IRN: Expiry: / /
Pension / HCC No: Please tick card type:	Expiry: / / Pension Concession Card ☐ Health Care Card ☐ Commonwealth Seniors Card ☐
DVA No. and colour:	Gold ☐ White ☐ Lilac ☐ Orange ☐
Occupation	
Medicare Head of Family: (all persons under 17)	For all patients under 17 years, Medicare requires a head of family, please fill out details of a guardian on the same Medicare card: Name: Relationship: Phone: DOB: Address:
Next of Kin:	Name: Relationship: Phone:
Emergency Contact:	Tick if same as Next of Kin ☐ OR Name: Relationship: Phone:

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 an ethnic or cultural background?

☐ No ☐ Yes - Please elaborate: ______________________________

Do you require an interpreter? Yes ☐ No ☐ If so, what language? ____________________

To assist with health initiatives – are you Aboriginal or Torres Strait Islander?

☐ Yes - Aboriginal ☐ Yes - Torres Strait Islander ☐ No

Where did you hear about Hamilton Doctors?

____

Doctor to complete
Medical details added to file
Date: ______
Signature: ______

Name: ______________________ D.O.B: ______________

Medical history: Do you have any of the following conditions/diseases?

☐ Asthma	☐ Hepatitis	☐ Thyroid conditions
☐ Emphysema/COPD	☐ Peptic Ulcer	☐ Diabetes/Gestational Diabetes
☐ Tuberculosis	☐ Gout	☐ Cancer of any type
☐ Heart Disease/Heart Attack	☐ Osteoporosis	☐ Anaemia
☐ Stroke	☐ Dermatitis/Eczema	☐ Abnormal pap smear
☐ High Blood Pressure	☐ Psoriasis	☐ Anxiety
☐ High Cholesterol	☐ Dementia	☐ Depression
☐ Glaucoma	☐ Migraines	☐ Schizophrenia
☐ Blood Clots	☐ Seizures/Fits	☐ Bipolar

Any other condition not listed above:

____

Please list any regular prescribed medications

____

____

Please list any over the counter medications (this includes vitamins, minerals, herbal remedies)

____

____

Do you have any medication/food/dressing allergies? Yes ☐ (please list below) No ☐

Medication/food/dressing	**Side effect/allergic response**
______________	______________
______________	______________

Women only: Date of last Cervical Screening Test: ____________ **Result: Normal / Abnormal**

Social History:

☐ Never Smoked
☐ Ex-Smoker
☐ Current Smoker: _____ per day

☐ Alcohol: I do not drink alcohol
☐ Alcohol: _____ drinks per day, _____days per week
☐ Alcohol: How often would you drink more than 6 drinks per day? _____

Height: __________ **cm** **Weight:** __________ **kg**

Social/Family Structure

Marital status:

☐ Married ☐ Defacto ☐ Single ☐ Widowed No. of children: ___________

☐ I am a minor

I live with:

☐ My spouse ☐ a relative ☐ a friend ☐ alone ☐ partner ☐ nursing home ☐ hostel

☐ I am a minor in care of parent/guardian.

Are you a carer for someone? ☐ Yes ☐ No Is someone a carer for you? ☐ Yes ☐ No

Consent

Our surgery requires the above information to maintain your records electronically. This form will be scanned into your patient file and securely stored. I give permission for my personal health information to be used for administrative purposes to assist in the running of this practice, this includes disclosure to others involved in your healthcare, such as treating Doctors within and outside this medical practice. This may occur through referral to other Doctors, or for medical tests and in the reports or results returned to my doctor following referrals.

Signature: ______________________________ **Date:** ______________________

HOT DOCS/ Communication / Reminder Consent Form

HOT DOCS: 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 appointment reminders and follow- up reminders by HOT DOCS through SMS text message are an additional service, which requires DOWNLOADING OF THE HOTDOC APP. 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 HOT DOCS 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 Reminders and Information

I consent to the practice contacting me by email for the purpose of health promotion, health reminders, practice news and general follow-ups for preventative care.

Emails are generated using HOT DOCS. I understand that they are transmitted over the internet and as such may not be secure. However, the practice will not transmit any information which would enable an individual patient to be identified. I understand I can cancel the email facility at any time.

I understand that any SMS text message and email I forward to the practice are transmitted over public phone networks and the internet and may be intercepted and not reach the practice.

Personal Information

This 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.

Recalls and Reminder 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 HOT DOC 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 reminders/notifications and agree to the terms and conditions. I give permission to be contacted by SMS text message and email through HOT DOCS system. To receive SMS reminders and results I am aware I must download the HOT Docs app through the app store on any smart phone.

Signature: ______________________________ **Date:** ______________

If applicable:

Guardian's full name: ______________________________

Relationship: ______________________________

Practice Address: 60 Lindsay Street HAMILTON

Phone: (02) 4961 3017

Fax: (02) 4961 3339

Postal Address: (PO Box 686) HAMILTON NSW 2303

www.hamiltondoctors.com.au

REQUEST FOR MEDICAL RECORDS

To: .... Fax: .... Phone: ....

The following patient/s are now attending our practice and request that <u>copies</u> of their medical records be forwarded to us.

Name	DOB	Address
....	....	....
....	....	....
....	....	....
....	....	....

PLEASE FILL OUT THIS SECTION AND FAX BACK – 02 4961 3339

Please advise us the dates of any assessments and/or reviews of assessments that may have been completed whilst the patient/s were under your care.

GPMP (721)	Date:
TCA (723)	Date:
Health Assessment (703, 705, 707)	Date:
GP Mental Health Plan (2715, 2717, 2700, 2712)	Date:
Diabetes Annual Cycle of Care (2517, 2521, 2525)	Date:

We can accept copies of medical records on disc as long as they are in **XML** format

- *Please note Hamilton Doctors has an entirely computerised system. The information you transfer will be shredded after the requesting doctor has viewed the file and been scanned into our computer record.*
- *Hamilton Doctors cannot accept responsibility for safekeeping of any original documents or consequences and liabilities from loss of original documents if they are sent to us.*
- *We prefer a summary of the patient's conditions, medications and recent attendances at your surgery, together with any relevant investigation results or specialist letters.*
- *Could you please include any significant historical items such as old ECG's, Cardio echo's etc that are likely to be valuable for future comparison.*
- ***The patient is responsible for any costs incurred in the process.***

I/We,.. state that I/we have read the above information and have consented to having previous records sent to Hamilton Doctor Surgery.

Signed:.. Date:..

Signed:.. Date:..