Ingham Family MEDICAL PRACTICE

Honesty & Integrity

INGHAM
22 Heard Street
Ingham QLD 4850
Fax: (07) 4776 6400
Phone: (07) 4776 2101

CARDWELL
75 Victoria Street
Cardwell QLD 4849
Phone: (07) 4227 2000
Fax: (07) 4066 8447

ABN: 95766180343
Po Box 1650
Ingham QLD 4850
Website: www.inghammedical.com.au
Email: ifmpadmin@inghammedical.com.au

Title: _____ Surname: _____ First Name: _____

Middle Name/s: _____ Preferred Name: _____

Date of Birth: _____ Birth Sex: Female / Male / Other / Unknown

Gender Identity: Male / Female / Non-binary / Gender Diverse / Transgender / Different identity

How would you like to be referred to: She/Her/Hers He/Him/His They/Them/Theirs

Do you identify as: Aboriginal Torres Strait Islander Both

Ethnicity (e.g. Australian, Italian, Filipino): _____

Street Address: _____

Postal Address: _____

Home Phone Number: _____ Work Phone Number: _____

Mobile: _____ Consent for SMS Appt & Clinical Reminder: Yes / No

Email:_____ (Email is not encrypted)

Preferred method of contact: Home Phone / Work Phone / Mobile / Email

Medicare Number: _____ Ref Number: _____ Expiry: _____

Pension Card Number: _____ Expiry: _____

Health Care Card Number: _____ Expiry: _____

DVA Card Number: _____ Type: White or Gold *Please circle*

Private Health Insurance Fund: _____ Number: _____

Next of Kin: _____ Relationship: _____ Phone No: _____

Emergency Contact: _____Relationship: _____ Phone No: _____

If you would like to transfer your records from another practice, please see our friendly reception staff to complete the relevant consent forms. If you would like to authorise a third party/another person to discuss your personal health record, please complete and sign consent attached to this new patient form. PLEASE NOTE: WE ARE NOT A BULK BILLING PRACTICE. WE ROUTINELY BB PENSION CARD HOLDERS AND CHILDREN 16 AND UNDER.

CONSENT FORM FOR COLLECTION AND USE OF PERSONAL INFORMATION (FULL PRIVACY POLICY ATTACHED)

Your medical record is a confidential document. It is the policy of this practice to maintain security of your personal health information at all times and to ensure that this information is only available to authorised members of staff. This consent form covers collection and use of your information to provide comprehensive, coordinated and continuing holistic medical care. Your information may be disclosed to other health care professionals to provide this level of care. Separate specific consent is required if your information is used for research, statistical or quality assurance purposes or if the practice changes ownership and the services offered are significantly different from those provided by this practice.

By signing this consent form you acknowledge that you agree to your information being collected and used for you by health care professionals. If you have any questions in relation to this consent form, please ask our staff or Doctors.

I have read and understood the consent form provided by the practice and I consent to the collection and use of my information as described in this consent form.

Signature of Patient/Person Responsible: _____ ***Date:*** _____

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PATIENT AUTHORISATION

I, ……..…… hereby authorise my:-

- *Spouse/partner:* _____

  DOB: _____

  Phone Number: _____

- *Family member:* _____

  DOB: _____

  Phone Number: _____

- *Friend*: _____

  DOB: _____

  Phone Number: _____

- *Other*: _____

  DOB: _____

  Phone Number: _____

to access my records and/or ask for and receive any results that he/she/they may request on my behalf.

SIGNED ……..…..

DATED ……

Please list your current chronic disease or illness:

_____

_____

_____

_____

Do you have any allergies/adverse drug reactions: Yes / No

Item: _____ Reaction: _____ Severity: □ Mild □ Moderate □ Severe

Item: _____ Reaction: _____ Severity: □ Mild □ Moderate □ Severe

Item: _____ Reaction: _____ Severity: □ Mild □ Moderate □ Severe

Item: _____ Reaction: _____ Severity: □ Mild □ Moderate □ Severe

Item: _____ Reaction: _____ Severity: □ Mild □ Moderate □ Severe

Please list any operations or surgeries you have had, the date and reason:

_____

_____

_____

Please list your current medications including any over the counter medications, vitamins, or Herbal remedies you take regularly, including the dose:

_____

_____

FAMILY AND SOCIAL HISTORY

☐ Unknown (eg Adopted) ☐ No significant Family History

Mother alive? ☐ Yes ☐ No Age of Death: _____ Cause of Death: _____

Father alive? ☐ Yes ☐ No Age of Death: _____ Cause of Death: _____

Significant Family History:

Mother ☐ Diabetes ☐ Hypertension ☐ Heart Disease
☐ Colon Cancer ☐ Depression ☐ Breast Cancer
☐ Stroke ☐ Other: _____

Father ☐ Diabetes ☐ Hypertension ☐ Heart Disease
☐ Colon Cancer ☐ Depression ☐ Breast Cancer
☐ Stroke ☐ Other: _____

Further Information:

_____

_____

Marital Status: _____

Sexuality: Lesbian ☐ Gay ☐ Bisexual ☐ Transgender ☐ Heterosexual ☐

Elite Athlete: Yes / No

Advanced Health Directive: Yes / No Enduring Power of Attorney: Yes / No

Recreational Activities: _____

Accommodation: _____ Lives with: _____

Do you have a carer? Yes / No (If under 16, your parent/guardian must be entered below)

If yes, carer details: Name: _____

Phone: _____

Relationship: _____

Do you feel safe in your own home? Yes / No

Current Occupation: _____ ☐ Retired

Australian Defence Service: _____

Current Alcohol Intake

Do you drink alcohol? Yes / No If yes, how many days per week do you drink? _____

How many standard drinks per day do you drink? _____

Past Alcohol Intake

☐ Nil ☐ Occasional ☐ Moderate ☐ Heavy

Year started: _____ Year stopped: _____

Current Smoking History

☐ Non smoker ☐ Ex Smoker ☐ Smoker

If you ticked non-smoker or ex-smoker:

How many a day did you smoke? _____

Year started: _____ Year stopped: _____

Would you like help to stop smoking? Yes / No

Do you consent to upload to the Cervical Screening Register: Yes / No *Please circle*

Do you consent to upload to My Health Record: Yes / No *Please circle*

Practice Nurse to complete:

Height: _____ Weight: _____ Waist Circumference: _____

BP: _____

Photo ID sighted and copy taken: Yes / No

The information obtained on this New Patient Form has been entered into the patients chart on Best Practice as is recorded, no alterations have been made.

Name of staff member: _____

Signature: _____ Date: _____