HOLLAND PARK
FAMILY MEDICAL PRACTICE

Welcome to Holland Park Family Medical Practice. We need this information to provide the best quality care. This form complies with the RACGP Standards for general practices. This means your personal health information is kept private and secure, as required by federal and state privacy laws.

- Please complete all sections and read the Personal & Health Information Consent section at the end of the form.
- If you have any concerns, please leave blank and discuss with your GP.

Title:	Surname:	First Name:		Middle Name:
	Preferred Name:			Date of Birth: / /
Gender:	□ Male □ Female □ Other			
Marital Status:	□ Single □ Married □ Defacto □ Separated □ Divorced □ Widowed			
Ethnicity:		Country of Birth:		
Street Address:				
	Suburb:			Post Code:
Postal Address (if different to street address):				
	Suburb:			Post Code:
Phone Number:	Home:	Mobile:		Work:
E-mail address:				
Best method of contact for Reminders & Preventative Care	□ Home Phone □ Mobile □ Mail □ Email			
For Health Initiatives – are you Aboriginal/Torres Strait Islander?	□ NO □ Aboriginal □ Torres Strait Islander □ Aboriginal & Torres Strait Islander			
Occupation:				
Medicare Number:		Ref:		Expiry:
DVA Number:		□ Gold □ White		Expiry:
Pension Card Number:				Expiry:
Health Care Card Number:		Ref:		Expiry:
Private Health Fund Name:		Number:		
Parent Details: (if patient is under 16 years)	Name:	Relationship:		Date of Birth: / /
Next of Kin:	Name:	Relationship:		Phone No:
Emergency Contact:	Name:	Relationship:		Phone No:
Advanced Health Directive:	□ YES □ NO	Speak to your GP for further information.		
Enduring Power of Attorney:	□ YES □ NO	Full Name:		
How did you find us?	□ Newsletter □ Referral □ Online □ Other ……			

P.T.O

PATIENT CONSENT

We respect your rights to privacy and take our privacy obligations seriously. We comply with the Australian Privacy Principles, found under the Privacy Act 1988 (Cth). Our Privacy Policy can be obtained from:

- Our Patient Brochure
- Our Reception Staff
- By calling us on (07) 3324 1677

We require your consent to collect personal information and health information about you. Please read this information carefully and sign where indicated below.

The Medical Centre collects information from you for the primary purpose of providing you with healthcare services. We require you to provide us with your personal and health information so that we may provide our services to you. We will also use the information you provide in the following ways:

- Effectively communicate with third parties, including Medicare Australia, private health insurers, government departments and other practitioners involved in your healthcare
- Appropriately manage our practice, such as conducting audits and undertaking accreditation processes, manage billings and training staff.

I have read the information above and understand why my information is collected and how it is used.

I acknowledge that I am not obliged to provide information requested of me, but that failure to do so might compromise the quality of care provided to me.

PLEASE BE AWARE the clinic has a Cancellation Policy. Should you need you to cancel an appointment, please contact the clinic within 2hrs notice.

Our Practice uses a reminder system to help us maintain your health. The Practice will contact you by phone, post and email for reminders such as vaccinations, care plans, procedures, Pap Smears and other health reviews.

I consent to being contacted with reminders to help me maintain my health. □ **YES** □ **NO**

I consent to receiving SMS reminders – the day before my appointment. □ **YES** □ **NO**

I consent to the handling of personal information of My Health Record □ **YES** □ **NO**

PATIENT'S NAME …… DATE OF BIRTH ……

PARENT/GUARDIAN NAME (If Patient is under 16 years) ……..

SIGNED …… DATE ……..

PATIENT NAME: _____

Do you have or have you had a history of the following? (please elaborate)

☐ Operations
☐ Asthma
☐ Chronic Illness
☐ Diabetes
☐ Hypertension
☐ Other

ALLERGIES/SENSITIVITIES

Do you have any allergies or are you sensitive to drugs or dressings?

IMMUNISATIONS

Have you had the following immunisations? (list date where appropriate)

Tetanus Booster	☐ Yes. Date:	☐ No
Hepatitis B	☐ Yes. Date:	☐ No
Hepatitis A	☐ Yes. Date:	☐ No
Influenza	☐ Yes. Date:	☐ No
Pneumococcal	☐ Yes. Date:	☐ No
Polio	☐ Yes. Date:	☐ No

Children's Immunisations

CURRENT MEDICATIONS

Please list all current medications including over the counter medications, vitamins and minerals:

FAMILY HISTORY

Have any members of your family had: (please elaborate)

☐ Heart Disease
☐ Diabetes
☐ Cancer
☐ Asthma
☐ Mental Illness

SOCIAL HISTORY

Do you use any of the following: (list amount where appropriate)

Tobacco	☐ No.	☐ Yes. Number ____ day / ____ week **or** ☐ Ceased smoking
Alcohol	☐ No.	☐ Yes. Number ____ days per week /Number of_____ drinks per day
Drug Use	☐ No.	☐ Yes. Type _____ / Frequency _____