KEPERRA FAMILY PRACTICE & SKIN CANCER CLINIC

NEW PATIENT FORM

PERSONAL DETAILS	
Title	
First name	
Surname	
Middle name	
Preferred name	
Date of birth	
Gender	
Street address	
Postal address (if different from above)	
Home phone	
Mobile phone	
Work phone	
Email	

EMERGENCY CONTACT DETAILS	
Full name	
Relationship to you	
Phone number	

NEXT OF KIN (IF DIFFERENT FROM EMERGENCY CONTACT)	
Full name	
Relationship to you	
Phone number	

COUNTRY OF BIRTH	
Country of birth	
Language spoken	

CULTURAL BACKGROUND	
Aboriginal	
Torres Strait Islander	
Aboriginal and Torres Strait Islander	

MEDICARE CARD	
Number	
Reference	
Expiry	

DEPARTMENT OF VETERAN AFFAIRS CARD - DVA	
Number	
Expiry	
Colour	Gold / White
Conditions covered if on a DVA White Card	

COMMONWEALTH CENTRELINK CARD	
Type	
Number	
Expiry	

PRIVATE HEALTH FUND	
Fund name	
Membership number	

HEAD OF FAMILY (For any private invoices for children under 16 years old)	
Full name	
Phone number	
Relationship	

PATIENT CONSENT

COMMUNICATION CONSENT

Do you consent to the following forms of communication? (Please circle)

SMS	Mobile number:	YES / NO
E-mail	E-mail address:	YES / NO

HEALTH INFORMATION COLLECTION, USE AND DISCLOSURE

This general practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose and treat illnesses and medical conditions, ensuring we are proactive in your health care.

We will treat your personal information as strictly private and confidential. We will only use or disclose it for purposes directly related to your care and treatment, or in ways that you would reasonably expect that we may use it for your ongoing care and treatment.

By signing below, you (as a patient/parent/guardian) are consenting to the collection of your personal information, and that it may be used or disclosed by the practice for the following purposes:

- Administrative purposes in the operation of our general practice.
- Billing purposes, including compliance with Medicare requirements.
- Follow-up reminder/recall notices for treatment and preventative healthcare, frequently issued by SMS.
- Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals.
- For legal related disclosure as required by a court of law (Eg. Subpoenas, etc.).
- For the purposes of research only where de-identified information is used.
- To comply with any legislative or regulatory requirements, e.g. notifiable diseases.
- For use when seeking treatment by other doctors in this practice.
- Monthly e-newsletter with health updates.

I have read the information above and understand the reasons why my information must be collected, and the purposes for which my information may be used or disclosed.
I give permission for my personal information to be collected, used and disclosed as described above. I understand only my relevant personal information will be provided to allow the above actions to be undertaken and I am free to withdraw, alter or restrict my consent at any time by notifying this practice in writing.

Patient name / Parent or Guardian: _____

Signature: _____ Date: _____

PERSONAL MEDICAL INFORMATION

Patient name	
Date of birth	

ALLERGIES	
Do you have any allergies or are you sensitive to drugs or dressing?	YES / NO
If YES:	
Drug / Product name	
Reaction	

CURRENT MEDICATIONS (Please include over the counter medications and vitamins as well)

HEALTH HISTORY – Please outline of you have any of the following	
Asthma	YES / NO
Diabetes	YES / NO
Hypertension	YES / NO
Chronic illness	YES / NO
Heart disease	YES / NO
Other significant	

FAMILY HEALTH HISTORY INFORMATION – Have any members of your family had?	
Heart disease	YES / NO
Asthma	YES / NO
Diabetes	YES / NO
Hypertension (High blood pressure)	YES / NO
Mental illness	YES / NO
Cancer	YES / NO If YES what type?
Other significant	

PAST SURGERIES

SKIN CHECK	
Have you had a skin check?	YES / NO
If YES please state when	

WOMEN'S HEALTH	
Have you had a cervical screening test	YES / NO
If YES	
Date	
Result	Normal / Abnormal
Have you had a breast check	YES / NO
If YES	
Date	
Result	Normal / Abnormal

MEN'S HEALTH	
When did you have an overall check-up?	
Have you had a prostate check	YES / NO
If YES	
Date	
Result	Normal / Abnormal

LIFESTYLE RISK FACTOR INFORMATION	
Do you smoke?	YES / NO
If YES how many per day?	
Do you drink alcohol?	YES/ NO
If YES how many drinks per day?	
Do you use recreational drugs?	YES / NO
If YES what type and how often?	

IMMUNISATIONS	
Are your childhood immunisations up to date?	YES / NO
Please state if you had any of the following immunisations:	
Tetanus	YES/ NO
Hepatitis A	YES/ NO
Hepatitis B	YES / NO
Influenza	YES/ NO
Pneumococcal vaccine (For over 65 years old)	YES/ NO
Shingles vaccine (If you are between 70 and 79 years old)	YES/ NO

BILLING POLICY

Keperra Family Practice is a pronominally private billing practice.

From 1st January 2023, bulk billing is available to:

- Childhood immunisations.
- DVA God Card holders and DVA White Card holders for specific conditions.
- Yearly Health Assessments for patients 75 years and over, Aboriginal and Torres Strait Islanders and those with Intellectual Disability.
- GP Management Care Plans and three-monthly reviews. These are aimed to improve and manage a chronic health condition over the 12-month period. The plans are a specific type of appointment available to all patients with certain chronic health conditions.

Full standard fees apply to face to face and telehealth consultations for all patients who do not hold a Commonwealth Concession Card.

Reduced fees are available for children, full-time students between the age of 16 and 25 years old and anyone holding a Commonwealth Concession Card, which include: Aged Pension Cards, Health Care Cards, Disability Pension Cards, Senior Cards and DVA Aged pension Cards (Not DVA Gold or White Cards). Reduced fees will incur an approximate $ 25.00 out-of-pocket amount for all face to face and telehealth consultations.

All consultations are required to be paid in full on the day of the appointment and the Medicare rebate will be processed immediately.