KEPERRA
FAMILY PRACTICE & SKIN CANCER CLINIC
Let our family care for your family!

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)

Appointment reminders via SMS	YES / NO
Clinical recall reminders via SMS or mail (EG. reminders for skin checks, annual health care plans, etc)	YES / NO
Notification of results via SMS	YES / NO

Signature: _____ Date: _____

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.

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