JEMA CLINIC
YOUR HEALTH IS OUR PRIORITY

NEW PATIENT FORM

TITLE (Please Circle):
Ms / Miss / Mrs / Mr / Master / Doctor / Other _____ Gender: Male / Female

First Name: _____ Surname: _____

Middle Name: _____ Preferred Name: _____

DOB: _____/_____/_____ Marital Status: Single Married De Facto Separated Widowed

MEDICARE
Card Number: __ __ __ __ __ __ __ __ __ __ Ref. Number: ____ Expiry: _____/_____

Health Care Card No: __ __ __ - __ __ __ - __ __ __ __ Expiry Date _____/_____/_____

Pension Card No: __ __ __ - __ __ __ - __ __ __ __ Expiry Date_____/_____/_____

DVA file number: _____ _____ Card Type (Please Circle): Gold White Orange

Do you have private health insurance? (Please Circle): Yes No

If yes, what is the name of your health fund: _____

CONTACT DETAILS

Home Address: _____ P/Code _____

Postal Address (if different to above address):
_____P/Code _____

Home Phone: _____ Work Phone: _____

Mobile Phone: _____ Email Address: _____

Country of Birth: Australia Other: _____ Occupation: _____

Are you (Please Circle): Aboriginal Torres Strait Islander
Aboriginal & Torres Strait Islander Neither

Religion:_____

NEXT OF KIN

Name: _____Phone: _____ Relationship: _____

EMERGENCY CONTACT PERSON

Name: _____Phone: _____Relationship:_____

If you would like an electronic reminder for appointments please circle: Email or SMS
If you would like to receive reminders regarding our preventive screening please circle: YES or NO

Social	**Yes**	**No**	**Yes, now**	
Cigarette	☐	☐	☐	_____ per day
Alcohol	☐	☐	☐	_____ per week
Intravenous drugs	☐	☐	☐	_____
Other drugs (marijuana)	☐	☐	☐	_____
Exercise	☐	☐	☐	_____

Allergy	Symptoms

Where did you hear about us? Word of mouth ☐ TV Ad ☐ Website ☐ Facebook ☐

THIS CLINIC DOES NOT PRESCRIBE DRUGS OF ADDICTION

IT'S PART OF JEMA CLINIC POLICY THAT FOR ANY CANCELLATIONS OUT OF COURTESY PLEASE CALL THE PRACTICE TO NOTIFY US WITHIN 24HRS OTHERWISE A FEE OF $30.00 WILL BE CHARGED.

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Medications

Name of medication	Strength	Times taken

Last Checked	Year
Cholesterol	
Blood Pressure	
Prostate check	
Pap smear	
Bowel cancer	
HIV test	
HIV test	

Immunisations:

	Year	Type:	Year
Birth		Tetanus	
2 month		Rubella	
4 month		Hepatitis A	
6 month		Hepatitis B	
12 month		Meningococcal	
18 month		Typhoid	
4 year		Chicken Pox	
Year 7		Influenza	
Year 10		Pneumonia	
		Measles	
		Cholera	

Have you ever had any major operations or been admitted to hospital?

Year	Reason

Have You ever had:	*Year began*	*Active now✓*		*Year began*	*Active now✓*
Heart Problems			Serious infection		
Angina			Skin rashes, dermatitis, eczema, psoriasis		
High blood pressure			Epilepsy/fits/blackouts/strokes		
High cholesterol			Migraine		
Varicose veins, clots or blocked arteries			Asthma/emphysema		
Stomach ulcers			Hay fever/ sinus problems		
Gall stones			Eye/ ear problems		
Liver disease, Jaundice, Hepatitis			Back/neck problems		
Pancreatitis			Serious trauma		
Hernia/ bowel problems			Emotional disorder/ stress		
Rectal bleeding			Kidney / urine/ bladder problems		
Diabetes			Prostrate problems/ impotence		
Thyroid problem			Abnormal pap smear		
Gout			Sexually transmitted disease		
Arthritis/Joint problems			AIDS		
Cancer-where?			Intravenous drug use		

Family History:

Mother: Alive: Yes ☐ No ☐ Age of Death: Cause of death:

Father: Alive: Yes ☐ No ☐ Age of Death: Cause of death:

Has anyone related to you ever had	**Relationship to you**	**Has anyone related to you ever had**	**Relationship to you**
High blood pressure		Asthma /emphysema	
High cholesterol		Tuberculosis	
Heart attack/angina		Arthritis	
Stroke		Diabetes	
Anaemia		Kidney disease	
Bleeding disorder		Cancer or tumor	
Asthma /emphysema		Other	

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NEW PATIENT FORM

Health Information Collection and Use Consent Form

As a patient of our medical practice we require you to provide us with your personal details and a full medical history, so that we may properly assess, diagnose, treat and be proactive in your health care needs.

We aim to protect the privacy and secure storage of your health information. You can request a copy of our privacy policy, which includes information about the collection, use and disclosure of your health information.

We require your consent to collect personal information about you and to use the information you provide in the following ways. Please read this consent form carefully, and sign where indicated below.

- Administrative purposes in running our medical practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your healthcare including treating doctors and specialists outside this medical practice. This may occur though referral to other doctors, or for medical tests and in the reports or results returned to us following referrals. This practice submits patient data to various disease specific registers (cervical, breast bowel screening etc) to assist with preventative health management.
- Disclosure to other doctors in the practice, locums etc. attached to the practice for the purpose of patient care and teaching.
- For research and quality assurance activities to improve individual and community health care and practice management. Usually information that does not identify you is used but should information that will identify you be required you will be informed and given the opportunity to "opt out" of any involvement.
- To comply with any legislative or regulatory requirements eg notifiable diseases.
- For reminder letters which may be sent to you regarding your health care and management.

You can decline to have your health information used in all or some of the ways outlined above but it may influence our ability to manage your health care to provide the best outcome for you.

I have read the information above and understand the reasons why my information must be collected.	☐
I understand that I am not obliged to provide any information requested of me, but failure to do so may compromise the quality of health care and treatment given to me.	☐
I am aware of my rights to access the information collected about me, except in some circumstances where access may be legitimately withheld. I will be given an explanation in these circumstances.	☐
I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.	☐
I consent to the handling of my information by the practice for the purpose set out above, subject to any limitations on access or disclosure of which I notify this practice.	☐
OR	
I am unsure and would like to discuss this further with someone from the medical practice before I sign.	☐

Patient's Name_____ Date_____/_____/_____

Patient's signature_____

Signed as Guardian for child_____

Name (printed) _____

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