BLACK FISH MEDICAL CLINIC

215-235 Rossiter Road, Koo Wee Rup, Vic 3981
Tel: (03) 5997 1819 Fax: (03) 5997 1980

NEW PATIENT INFORMATION FORM

Medicare Number: _____ Ref Number: _____ Expiry Date: _____

Health Care Card/ Pension Card Number: _____ Expiry Date: _____

Title: Mr. / Mrs. / Ms. / Miss: _____ Marital Status: _____

Surname: _____ Given Name: _____

Address: _____

Home Ph: _____ Work Ph: _____ Mobile: _____

Date of Birth: _____ Country of Birth: _____/ Year of Arrival in Aus: _____

Occupation: _____ Ethnicity: _____

Email Address: _____

Emergency Contact:

Name: _____ Contact Number: _____

Relationship: _____

Next of Kin:

Name: _____ Contact Number: _____

Relationship: _____

Do you agree to have reminders (e.g.: pap smears, immunisations etc) sent to you? YES / NO

Do you agree to have contact made at the phone numbers listed above (including SMS and email messages) ? YES / NO

Do you identify as someone from a cultural and/or diverse background? If yes, please explain.

_____

To assist with health initiatives, are you Aboriginal or Torres Strait Islander? YES / NO

If yes, please circle which one: ABORIGINAL / TORRES STRAIT ISLANDER.

I declare that the information given is true and correct and has my approval.

Sign: _____ Date: _____

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PATIENT HEALTH INFORMATION CONSENT FORM

Name:_____ D.O.B: _____/_____/_____

Do you suffer from any of the following? Please indicate

	YES	NO		YES	NO
High blood pressure	☐	☐	Diabetes	☐	☐
Heart ailment	☐	☐	Depression	☐	☐
Rheumatic fever	☐	☐	Excessive bleeding or blood disorder	☐	☐
Asthma, chest or breathing problems	☐	☐	Epilepsy	☐	☐
Tuberculosis	☐	☐	Hepatitis	☐	☐
Stomach or bowel problems	☐	☐	AIDS/HIV	☐	☐
Kidney disease	☐	☐	Osteoporosis	☐	☐
Do you smoke?	☐	☐	How many a day?_____		

List any previous illness: _____

_____

List any other Medical conditions the doctor should be aware of:_____

Do you have an artificial hip, heart valve or other prosthetic implant?_____

Are you taking any drugs, medicines or tablets? If yes, please list:_____

_____

	YES	NO	
Are you pregnant?	☐	☐	If so, how many weeks? _____
Do you have any allergies?	☐	☐	

Please list any medicines or products you are allergic to (e.g.Penicillin, Latex…):_____

_____

Date of your last (If applicable):

Pap smear:_____ Breast Check:_____ Prostate Check:_____

Weight:_____ Height:_____

FAMILY MEDICAL HISTORY

Do close members of your family suffer from any medical condition which the doctors should be aware of? E.g.: Heart Disease, Cancer, Diabetes?

_____

_____

Black Fish
MEDICAL CLINIC

215-235 Rossiter Road, Koo Wee Rup VIC 3981

T 5997 1819 F 5997 1980 E reception@blackfishmedicalclinic.com.au

PATIENT HEALTH INFORMATION CONSENT FORM

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

This medical 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, treat and be proactive in your health care needs. This means we will use the information you provide in the following ways:

- Administrative purposes in running our medical clinic.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- 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.
- Disclosure to other doctors in the practice, locums and by Registrars attached to the practice for the purpose of patient care and teaching. Please let us know if you do not want your records accessed for these purposes, and we will note your record accordingly.
- Disclosure for research and quality assurance activities to improve individual and community health care and practice management. You will be informed when such activities are being conducted and given the opportunity to "opt out" of any involvement.
- Disclosure to other organizations where required by law or if necessary for debt recovery purposes.

I have read the information above and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling patient information.

I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to me.

I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.

I understand that if my information is to be used for purposes other than those set out above, my further consent will be obtained.

I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure that I notify this practice of.

WE EXPECT PAYMENT OF ACCOUNTS ON THE DAY OF SERVICE PLEASE
ALL ACCOUNTS ARE DISCOURAGED AND EXTRA FEES MAY APPLY TO ACCOUNTS THAT ARE NOT PAID ON THE DAY OF SERVICE.

Please print name: ..... Signed: .....Date: .....