NEW PATIENT DETAILS FORM

TOOWOOMBA MEDICAL CENTRE

Date of Initial Consultation _____/_____/_____

Welcome to our practice. To enable us to provide you with the best care please complete our health questionnaire.
This information is strictly confidential, and every question is important!

Title: Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Master ☐ Doctor ☐
Last Name: _____ ***Given Names:*** _____
Date of Birth: _____/_____/_____
Gender: _____
Nationality: _____
Marital Status: _____
What was your sex recorded at birth (Please Circle) – Male / Female
How do you describe your gender – Male or man / Female or Woman / Non-binary / Transgender / Gender Diverse / Prefer not to say
Marital status - Single / Married / De facto / Separated / Divorced / Widowed
Living Arrangement: Accommodation / Own Home / Rental / Age Care / Relative Home **Living with:** Partner / Relative / Alone / Other

Street Address: _____
Suburb: _____ ***Post Code:*** ___ ___ ___ ___
Home Phone No: _____ **Work Phone No:** _____ ***Mobile No:*** _____
Email: _____ **Occupation:** _____

What is your cultural background? _____
Country *of Birth:* _____
Are you of Aboriginal or Torres Strait Islander origin?
No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Both, Aboriginal and Torres Strait Islander ☐
If yes, are you registered with the Closing the Gap program? Yes ☐ No ☐
Is English your first language? Yes ☐ No☐ ***If English is not your first language, do you require an interpreter?*** Yes ☐ No ☐
What is your preferred language for an interpreter? _____

Medicare Card No: ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ***Ref.*** ____ ***Expiry Date***: _____
Health Care Card? ☐ **or *Pensioner Concession Card?*** ☐
Card number: _____ ***Card Expiry Date:*** _____
Private Health Insurance Fund _____ **Member No:** _____ **Ref:** _____
DVA Card No: _____ ***Expiry Date***: _____ **Gold** **White**
Are you registered with a MyHealth Record? Yes ☐ No ☐

Next of Kin _____
Relationship _____
***Phone* No** _____

Emergency Contact _____
Relationship _____
***Phone* No** _____

Do you give consent for a family member to receive appointment reminders, Yes ☐ No ☐ ***or recall results*** *Yes* ☐ No ☐
If yes - PLEASE COMPLETE THE FOLLOWING:
APPOINTMENT REMINDERS: ***RECALL RESULTS:***
Name _____ ***Name:*** _____
Phone: _____ **Phone:** _____

How did you hear about this practice? (It is ok to tick more than one box)
Google Search ☐ Doctor ☐ Newspaper ☐ Facebook ☐ Yellow Pages ☐ Employer ☐
Friends or Family ☐ Passing by ☐ Signage ☐ Quest Hotel ☐ Other _____

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MEDICAL CENTRE

YOUR HEALTH HISTORY – Do you have, or have you had a history of? (Please tick and specify below)

☐ Operations	☐ Asthma	☐ Diabetes	☐ Hypertension	☐ Cancer
☐ High blood pressure	☐ Heart Disease	☐ Chest Pain	☐ Shortness of Breath	☐ Epilepsy
☐ Dizzy Spells	☐ Kidney Disease	☐ Anxiety	☐ Depression	☐ Sleep Apnoea

If you have ticked any of the above, please specify with more details below:

_____

_____

Medications - Please list all medications (including over the counter medications, vitamins and minerals):

Name	**Frequency (Daily, Weekly etc)**

Do you have a preferred pharmacy (If so which one)?.....

Immunisations

Are your immunisations up to date? (Children and Adults)

Yes No

History

_____

_____

_____

Family History – have any members of your family had:

Mother	**Father**
☐ Diabetes	☐ Diabetes
☐ Asthma	☐ Asthma
☐ Heart Disease	☐ Heart Disease
☐ Mental Illness	☐ Mental Illness
☐ Cancer	☐ Cancer

Allergies

Do you have any allergies? E.g. food, medication, type of dressings?

☐Yes (Please Specify) ☐ No

Allergen	**Reaction**	**Severity**
e.g., Fish	e.g., Swelling	E.g., Severe

_____

_____

_____

Social History

Tobacco — Cigarettes per day: _____

Year Started _____

Alcohol — Days per week: _____

Drinks per day: _____

Physical activity — How many days per week: _____

How long duration: _____

Females – When did you last have?

Cervical Screening	Yes	Year _____	Never
Breast Check	Yes	Year _____	Never
Mammogram	Yes	Year _____	Never
Bowel Cancer Screening	Yes	Year _____	Never

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MEDICAL CENTRE

Males – When did you last have?

Prostate Examination	Yes	Year _____	Never
Bowel Cancer Screening	Yes	Year _____	Never

For those over 65 years – when was the last time you were immunised for:

Influenza	☐	Yes	Date ___/___/____	☐	Not Sure	☐ Never
Pneumococcal Pneumonia	☐	Yes	Date ___/___/____	☐	Not Sure	☐ Never
Other	☐	Yes	Date ___/___/____	☐	Not Sure	☐ Never

PRACTICE CONSULTATION FEES

I acknowledge that Toowoomba Medical Centre is not a bulk billing facility and that a fee may be due at the end of my visit.
I acknowledge that I will be required to pay the full fee and that the Medicare rebate will come back into my account overnight.
The fees below commenced on 1 July 2023.

CONSULTATION	TIME	FEE	CONCESSION FEE	MEDICARE REBATE
Standard Consultation	5-15 minutes	$82.00	$61	$41.20
Long Consultation	15-30 minutes	$119.00	$98	$79.70
Extended Consultation	30-45 minutes	$155.00	$135	$117.40

PENSION CARD/HEALTH CARE CARD HOLDERS WILL BE BILLED A CONCESSION FEE (GAP is approx. $19.80) *
CHILDREN UNDER 16 years and Care Plans WILL BE BULK BILLED FOR THEIR APPOINTMENTS

I acknowledge the billing policy of the practice and agree to these fees and terms.

Signature: …… **Date: _____ / _____ / _____**

FOR PRIVACY CONSENT

PLEASE TURNOVER PAGE

TOOWOOMBA
MEDICAL CENTRE

CONSENT FORM - PRIVACY

This privacy policy is to provide information to you, our patient, on how your personal information (which includes your health information) is collected and used within our practice, and the circumstances in which we may share it with third parties.

When you register as a patient of our practice, you provide consent for our GPs and practice staff to access and use your personal information so they can provide you with the best possible healthcare. Only staff who need to see your personal information will have access to it. If we need to use your information for anything else, we will seek additional consent from you to do this.

This medical practice collects your personal information for the purpose of providing quality healthcare services to you. Our main purpose for collecting, using, holding, and sharing your personal information is to manage your health. The information we will collect about you includes your:

- Names, date of birth, addresses, contact details.
- Medical information including medical history, medications, allergies, adverse events, immunisations, social history, family history and risk factors.
- Medicare number (where available) for identification and claiming purposes.
- Healthcare identifiers.
- Health fund details.

Under the Privacy Act 1988, you have the right to deal with us anonymously or under a pseudonym unless it is impracticable for us to do so or unless we are required or authorised by law to only deal with identified individuals.

We sometimes share your personal information:

- with third parties who work with our practice for business purposes, such as accreditation agencies or information technology providers – these third parties are required to comply with APPs and this policy.
- with other healthcare providers.
- when it is required or authorised by law (eg court subpoenas).
- when it is necessary to lessen or prevent a serious threat to a patient's life, health or safety or public health or safety, or it is impractical to obtain the patient's consent.
- to assist in locating a missing person.
- to establish, exercise or defend an equitable claim.
- for the purpose of confidential dispute resolution process.
- when there is a statutory requirement to share certain personal information (eg some diseases require mandatory notification).
- during the course of providing medical services, through My Health Record (eg via Shared Health Summary, Event Summary).

Only people who need to access your information will be able to do so. Other than in the course of providing medical services or as otherwise described in this policy, our practice will not share personal information with any third party without your consent.

Your personal information will be stored electronically at our practice and all personal information will be stored securely. You have the right to request access to, and correction of, your personal information. Our practice will take reasonable steps to correct your personal information where the information is not accurate or up to date. From time to time, we will ask you to verify that your personal information held by our practice is correct and current. You may also request that we correct or update your information, and you should make such requests in writing to practicemanager@toowoombamedicalcentre.com.au

CONSENT

- I have read the information above and understand 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 my failure to do so might compromise the quality of my health care and treatment given to me.
- I understand that if any information is to be used for any other purposes other than set out above, my further consent will be obtained.
- I consent to the handling of my information by this practice for the purpose set out above, subject to my limitations on assess or disclosure that I notify the practice of.

Patient's Full Name:……

Signature:……

Date:……

FOR COMMUNICATIONS CONSENT

PLEASE TURNOVER PAGE

TOOWOOMBA
MEDICAL CENTRE

CONSENT FORM – COMMUNICATION

This practice has implemented technology solutions to enable communications with our patients via SMS by using third party providers. With your consent we may disclose your personal information (including health information) to assist in sending you appointment and clinical reminders, clinical communications, and as necessary health awareness reminders.

Please choose a preferred contact method:

Phone ☐ Letter ☐ SMS ☐ Please do not contact me in any method ☐

eScript – Allow scripts to be sent digitally to your mobile phone. This can then be taken directly to the pharmacy. A paper script can also be requested at any appointment if preferred.

eScript enabled ☐ Not at this time ☐

Consent

- I consent to the communication methods that I have indicated above, and should I change my preferences in the future, will notify the practice either in writing or verbally and this change recorded in my medical history.
- I consent that I understand that some third-party providers are involved with the practice and may receive some of my personal information to facilitate in communication methods.

Patient's Full Name:……

Signature:……

Date:……