Bicton Medical Clinic
3 Westbury Crescent
Bicton WA 6157
Tel: 9339 4744

This information is private and confidential and is for use in your clinical file only.

NEW PATIENT DETAILS - Please print and give as much detail as possible to assist us to provide quality care.

Full name: Mr/ Mrs /Ms /Miss/ Dr / Surname: ……First Name:……Middle Name:……..

Date of Birth: ……/……/……. Ethnicity: Aboriginal TSI ATSI Other……..

Country of Birth…….. Australian? Yes / No.

Address: ……

Suburb:…….. Postcode:……..

Phone:……Mobile:……

Business Tel:……contact at work Yes/No……

Email Address:……Do you consent to SMS contact? : Yes / No

Medicare or Vet Affairs No……Ref no……(next to name) Exp……..

Pension/Healthcare Card No…….. Exp…… Private Insurance ……

Next of Kin…… Relationship…….

Address (If different from the above) ……

Phone Emergency Contact Person…….. Relationship:……..

Contact Phone No:……Mobile Phone No:……Business No:……..

Preferred Method of Contact (please circle): Mobile SMS Email Home Phone Work Phone

Do you agree to register for my health record Yes / No

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PRIVACY CONSENT FORM

I give permission for the Doctor's at Bicton Medical Clinic to collect, use and disclose my personal information as outlined. I understand that I am able to withdraw my consent as to the use and disclosure of my personal information except when legal obligations must be met. I am aware that I am entitled to access my own health records as outlined in the Practice Privacy policy except where access would be denied as per the Privacy Act 1988 guidelines.

Patient Consent to Collect and Disclose Information

The Privacy Act 1988 requires Medical Practitioners to obtain consent from you, the patient, to collect, use and disclose your personal information. This information is needed to properly treat and advise you, and may be collected by the Medical Practitioner or our practice staff.

Normally we would collect the information directly from you but there may be occasions when we will need to obtain the information from others, such as:

1. Other general Medical Practitioners and Specialists.
2. Other health professionals such as physiotherapists, psychologists, psychiatrists, pharmacists, nurses, dentists, etc.
3. Hospital and Day Surgery facilities.

In an emergency we may need to obtain personal information from relatives or other sources if we are unable to obtain your express prior consent.

Information collected, used and disclosed may include full medical history, family medical history, genetic and ethnicity details.

Use and Disclosure

The Practice will only use your personal and heaith information for the following reasons:

1. Referral to a Medical Specialist or another health care provider.
2. Provision of a prescription in digital form to a pharmacy to which you have taken a prescription.
3. Referral to a hospital for treatment and advice.
4. Advice on treatment options.
5. To prevent or lessen a serious threat to an individual's life, health or safety.
6. Where legally required to do so, such as providing records to a court, mandatory reporting of child abuse or the notification of diagnosis of certain communicable diseases.
7. Account keeping and billing purposes.
8. To meet our obligations of notification to our insurers and medical defence organisation.

Access to your Records

You are entitled to access your own health records at any time convenient to both yourself and the Practice.

Consent to be included in the Practice reminder s stem

In order to provide continuity of care, and in the interests of preventative medical management the Practice maintains a reminder system. Your consent is needed to be a participant in the recall system, and you have the right to refuse if you wish.

SIGNATURE/ Date_____ PRINT NAME _____

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PLEASE TAKE THIS SECTION TO DOCTOR

Full name: Mr/ Mrs /Ms /Miss/ Dr/ Surname: _____First Name:_____Middle Name:_____

Date of Birth:___/ ___/____

Current Medications and Doses:_____

Please list any known allergies; list nil known if none: _____

Please list any operations or previous illnesses:_____

FEMALE PATIENTS: Date of last Pap Smear: _____ Result:_____

SOCIAL HISTORY: Please circle the most appropriate answer fill out all other areas

Do you drink alcohol? Yes / No. If yes Number Standard drink per day_____ Days per week_____

Do you Smoke ? Yes / No. If yes quantity per day ? …… Ex-smoker? Yes / No. Year stopping……

FAMILY HISTORY: Please circle the most appropriate answer fill out all other areas

Family History: Unknown (e.g Adopted) No significant family history Other — see list below

Mother: Still alive: Yes/ No If no Age at Death: ……..

Diabetes/ Kidney Disease /Asthma/ High Blood Pressure/Heart Problems/ Breast Cancer /Stroke /Depression
Epilepsy Other Cancer

Father: Still alive: Yes / No If no Age at Death: _____

Diabetes/Kidney Disease/Asthma/ High Blood Pressure/ Heart Problems /Stroke /Depression/ Epilepsy/ Other Cancer

Other immediate family members significant illness:

Do you know your blood group? Yes / No If yes what group are you?.....

At Bicton Medical Clinic we strive to provide high quality care, appropriate to meet our client's health care requirements.

How did you find out about our surgery?

Word of Mouth White Pages Yellow pages Relatives Drive/walk past Google