Newtown Medical

NEW PATIENT INFORMATION FORM

Please help us to provide the best possible patient care by completing the following pages

** = This information is completely voluntary and may help individualise and enhance your care. Any information is strictly private and confidential*

TITLE	Mr Mrs Ms Miss Mst Other				
SURNAME		**FIRST NAME**			
DATE OF BIRTH	/ /	***GENDER (please circle)**	Male	Female	Non-Binary / Prefer not to say
ADDRESS		**PRONOUNS**			
		POSTCODE			
ARE YOU:	Single ☐ Married ☐ De Facto Separated ☐ Separated ☐ Divorced ☐ Widowed ☐				
COUNTRY OF BIRTH	Australia ☐ Other _____				
CULTURAL & ETHNIC BACKGROUND	Australia ☐ Other _____				
MAILING ADDRESS					
		POSTCODE			
PHONE NUMBERS	Mobile:	Home:	Work:		
MEDICARE CARE		REFERENCE No. (next to name)	EXP		
DVA NUMBER		☐ GOLD ☐ WHITE	EXP		
PENSION or HEALTHCARE CARD	CRN:	EXP			
PRIVATE HEALTH INSURANCE	Name of Company				
NEXT OF KIN	Name:..... Phone:..... Relationship to you:.....	**EMERGENCY CONTACT Different to Next Of Kin please**	Name:..... Phone:..... Relationship to you:.....		
YOUR EMAIL					
How did you hear of us?	Google ☐ Recommendation ☐ Passing By ☐ Social Media ☐ Other ☐				
***To tailor appropriate care, encourage understanding and appreciation between people and cultures – do you identify as someone from a culturally and/or linguistically diverse background?**	☐ No ☐ Yes, please elaborate _____ Do you require an interpreter service? ☐ Yes ☐ No If yes, what language.....				
Are you (is the patient) of Aboriginal or Torres Strait Islander origin?	☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ None				
MEASUREMENTS	☐ Height ..... cm	☐ Weight ..... kg			
ACTIVITY LEVEL	☐ Inactive	☐ Moderately Active	☐ Active		
SMOKING HISTORY	☐ Non-smoker				
	☐ Ex-smoker	Year stopped	☐ Light	☐ Moderate	☐ Heavy
	☐ Current smoker	Per day	Year started		
CURRENT ALCOHOL INTAKE	☐ Non-drinker				
	☐ Drinker	Days per week	Standard drinks per day		
ALLERGIES *Are you sensitive to anything? Food, medications, dressings etc...	☐ No ☐ Yes, please list allergy and reaction				
ANY SIGNIFICANT PAST MEDICAL HISTORY?					
ANY SIGNIFICANT FAMILY HISTORY?					

Do you authorise the practice to send you SMS appointment confirmations? YES / NO

Our practice provides our patients with preventive care and early case detection reminders e.g. immunisations, annual health checks, skin checks and Pap smears

Do you wish to have any relevant reminders sent to you?

□ Yes – via mail ***OR*** **□ Yes – SMS to this ph no: _____ □ No**

Your Health Information

To enable ongoing care and total quality improvement within this practice and in keeping with the Privacy Act (1988) and the Australian Privacy Principles , we wish to provide you with sufficient information on how your personal health information may be used or disclosed and record your consent or restrictions to this consent.

Your personal health information will only be used for the purposes for which it was collected, or as otherwise permitted by law and we respect your right to determine how your personal health information is used or disclosed.

The information we collected may be collected by a number of different methods and examples may include: medical test results, notes form consultations, Medicare and health insurance details, data collected from observations and conversations with you (including the use of medical transcription software), and details obtained from other health care providers (e.g. specialist correspondence).

By signing below, you (as a patient/guardian) are consenting, that on obtaining your personal health information it may be used or disclosed by the practice for the following purposes:

- follow up reminder/recall notices for treatment and preventive healthcare;
- for accounting procedures and the collection of professional fees;
- the diagnosis and treatment of any health condition, including the communication of relevant information only, to practice staff, specialists and other healthcare providers to ensure quality care is provided;
- Accreditation and Quality Assurance activities are conducted by professionally trained non-treating GPs and other professionally trained and qualified persons, e.g. General Practice Managers;
- For legal related disclosures as required by Court of Law;
- For the purposes of research where de-identified information is used;
- To allow medical students and staff to participate in medical training/teaching using only de-identified information;
- For disease notification as required by law;
- For use when seeking treatment by other doctors in this practice.

At all times, we are required to ensure your details are treated with the utmost confidentiality. Your records are very important and we will take all steps necessary to ensure they remain confidential.

I, _____, give my permission for my personal health information to be collected, used and disclosed above. I understand only my relevant personal health information will be provided to allow the above actions to be undertaken and I am free to withdraw, alter to restrict my consent at any time by notifying this practice in writing.

Patient (please print): _____

Signature: _____ Date: _____

If not the Patient signing – Your name (please print): _____

Policy and Patient Consent – Use of AI Scribe Software

At our practice, some of our GPs use **AI scribe software** to help with recording and preparing clinical notes during consultations.

- The software securely transcribes parts of the consultation to assist the doctor in writing accurate notes.
- All audio recordings are immediately deleted once the notes are transcribed.
- The software is designed to comply with the Privacy Act 1988 and the Australian Privacy Principles, ensuring your information is protected at all times.
- Only your GP has access to the notes created, which are stored in your confidential medical record.

Patient Consent
I understand that my GP may use AI scribe software during my consultation only with my verbal permission on each consult. I consent to the use of this software for the purpose of creating accurate medical notes.

☐ I consent
☐ I do not consent

Patient Name: _____
Signature: _____
Date: _____