

Jupiter Health Spearwood NEW PATIENT FORM

This information is private and confidential and is for use in your clinical file only. **Please write clearly to avoid errors.**

Personal Details:										
Title (Please circle)	Mr	Mrs	Ms	Miss	Dr	Other:				
Gender identity (Please Circle)	Female	Male	Non – Binary	Gender – Diverse	Transgender	Different identity				
Pronoun (Please circle)	She/Her/Hers		He/Him/His			They/Them/Theirs				
Surname (as on Medicare Card)				Date of Birth						
First Name				Middle Name						
Street Address				Preferred Name						
Suburb				Post Code						
Home Phone:				Mobile Phone:				Work Phone:		
Email address:										
PLEASE NOTE: Appointment/Clinical Reminders/Clinical Communications & Health Awareness SMS reminders are an automatic service. If you would like to opt out of this service please advise reception.										
Do you consent to receive any monthly marketing emails or messages from Jupiter Health and Medical Services?							Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Preferred Contact Method: (Please circle) Home phone Work phone Mobile phone										
Occupation:			Past Occupation							
How did you hear about us?	Local Resident	Family or Friend	Google	Website	Facebook or Instagram	Health Engine	Word of mouth	Other (please specify)		

Health Care Details:										
Medicare Number	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>					Position on Card: (Circle)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		Expiry:	
Government Health Care Card, Pension, D.V.A?					Please Circle: YES NO					
Private Health Insurance (if any)	Number:			Company:			Expiry Date (if applicable):			
DVA Gold / White (Please Circle)	Number:						Expiry Date:			
Health Care Card: (Green)	Number:						Expiry Date:			
Pension Card: (Blue/Red)	Number:						Expiry Date:			

Emergency Contact Details:		
Next of Kin (Name):	Contact Number:	Relationship:
Emergency Contact (Name):	Contact Number:	Relationship:

Australia is a genuinely multicultural society. To tailor appropriate care, encourage understanding and appreciation between people from different nationalities and backgrounds please complete this section.

Country of Birth:	
Do you require a Translator? Yes No	Ethnicity:
To assist with health initiatives – are you Aboriginal or Torres Strait Islander? (please circle)	
Aboriginal	Torres Strait Islander
Aboriginal & Torres Strait Islander	No

CANCELLATION POLICY

Please telephone the surgery to cancel at least 4 hours prior to your appointment. This will allow the doctors to reschedule in another patient who needs to be consulted; failing to do this will result in a charge of \$40.00 per single appointment (10 minutes) or \$80.00 per double (20 minutes +) appointment.

DID NOT ATTEND APPOINTMENTS – Failing to turn up for your appointment, will also result in a charge of \$40.00 per single appointment (10 minutes) or \$80.00 per double (20 minutes +) appointment. By missing appointments this denies other patients who need to be consulted.

Signature _____ Date ____ / ____ / ____

Please continue to page 2

PLEASE COMPLETE AND TAKE THIS SECTION TO YOUR DOCTOR

Surname: _____ First Name: _____ Date of Birth ___/___/___

Current medications (including over the counter medication, vitamins, minerals and/or health supplements):

Do you have any allergies or are you sensitive to drugs or dressings?

Yes (Please specify below) No

Your Health History: Do you have or have a history of? (please tick)			
<input type="checkbox"/>	Operations (give details):	<input type="checkbox"/>	Hypertension
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Other (give details):
Do you know your blood group?	Yes	No	Blood Group:
Do you live with a carer?	Yes	No	Name & Contact:

If this information is for your child, please provide a copy of your child's immunisation history to the receptionist.

Family History: Have any members of your family had? (please circle)
Diabetes/Asthma/Heart Disease (Give Details)
Mental Illness/Cancer/Other (Give Details)

NOTE: This section may not be applicable for some patients.

Social History:	
Do you smoke? Yes: Amount _____/per day No	Past smoking history: Nil Light Moderate Heavy Which year did you stop smoking? _____
How many days per week do you drink alcohol? ___ days How many standard drinks do you drink in one day? ___	Past drinking history: Nil Light Moderate Heavy Which year did you stop drinking? _____
Females: When did you last have? Pap Smear Date: _____ Not Sure/Never Would you like us to find the date of your last Pap Smear? Yes/No Breast Check Date: _____ Not Sure/Never	For those 65 years and older: When was the last time you were immunised? Influenza Date: _____ Not Sure/Never Pneumococcal Date: _____ Not Sure/Never

I understand that Jupiter Health Spearwood complies with the Privacy Act (1988) and Privacy Amendment Act (2000) and as part of their Privacy Policy they are committed to protecting the privacy of the personal information of individuals. The purpose of collecting my personal details is to provide quality medical and health services and related account keeping. I understand that I have the right to request access to my information. Jupiter Health Spearwood makes every effort to keep my data in accordance with the National Privacy Principles and keep my records accurate and up to date. I understand that I may withdraw my consent to Jupiter Health Spearwood to use and disclose my personal information (except where legal obligations are met).

Collection, Use and Disclosure:

We recognise that the information we collect is often of a highly sensitive nature and as an organisation have adopted the highest privacy compliance standards relevant to ensure personal information is protected. We are a service company to the medical practitioners who provide services at our practice. For administrative and billing purposes, and to enable the patient to be attended by other practitioners at our practice, patient information is shared between practitioners who attend a patient. We (on behalf of) and the practitioners may collect personal information including health information regarding patients for the purpose of providing medical services and treatments to patients. Personal information collected will generally include patient name, address, phone number, Medicare, current drugs and treatments used by patient, previous and current medical history, including where clinically relevant family medical history, name of any health service provider or specialist to whom the patient is referred, copies of any letters of referrals and copies of any reports back.

By Signing below, I the patient (or parent/legal guardian of patient) have read and consent to the above and acknowledge that personal information collected by us may be used or disclosed:

- Jupiter Health Spearwood will be collecting, using, storing and disposing of my personal information
- Patient is aware of the terms and conditions with services that we provide and do not provide.
- The release of relevant personal information to other health professionals to allow quality medical care e.g., specialists, pathologists, usual GP, some fees may be incurred for transfer of records.
- Any additional visits to external service providers such as pathology, specialists, imaging etc may incur an additional fee that is independent to the fees associated with Jupiter Health Spearwood
- To have my records reviewed by accreditation surveyors as part of this practice's accreditation process should my records be randomly chosen for quality assurance, training, billing, liaising with government offices regarding Medicare entitlements and payments and as may be required by our insurers.
- DE identified data collection for research and population health planning purpose.
- The release of relevant personal information to my employer/prospective employer, their authorised representative, and their insurer in the case of a work-related consultation service.
- Jupiter Health Spearwood may/will use your mobile phone number for the purpose of SMS recall and reminder systems.
- Jupiter Health Spearwood will collect information necessary for your treatment. This may include Full Medical and Psychological History;
- Where there is a serious and imminent threat to an individual's life, health, or safety, or a serious threat to a public health or public safety or as required under compulsion or law.

We may access information:

- Provided directly by the patient, provided on a patient's behalf with the patients consent, from a health service provider who refers the patient to medical practitioners, from health service providers to whom patients are referred.
- Other than as described in the Policy or permitted under the National Privacy Act, Jupiter Health Spearwood uses its reasonable endeavours to ensure that identifying health information is not disclosed to any person

Signature _____ Date _____/_____/_____

Printed Name _____ (If the patient is under 16 years the parent/guardian is to sign)