LOWNDES STREET CLINIC

2/9 Lowndes St, Kennington VIC 3550
Ph: 03 5443 5117 Fax: 03 5443 5200
www.lowndesstreetclinic.com
admin@lowndesstreetclinic.com

New Patient Information Form

We are committed to providing our patients with the best care. To do this, it is essential that your health record is kept up to date and accurate.

Could you please assist us by completing the following:		
Title : o Dr o Mr o Mrs o Ms o Miss o Master o Mx	**Date of Birth :**	
Full Name :	**Occupation:**	
Full Address :	**Home Phone :**	
Mobile Phone :	**Email :**	

Medicare Number, Ref, Expiry	#:	Expiry:
o **DVA Gold** o **DVA White** (Please tick which)	#:	Expiry:
Pension Number	#:	Expiry:
Health Care Card Number	#:	Expiry:
Private Health Cover	Name: #:	Expiry:
Next of Kin (Name and Telephone number)		
Emergency Contact (Name and Telephone number of the person we can contact if needed)		

How did You hear about the practice?

oYellow pages oGoogle o Other Internet search oBusiness card
oStreet Sign oWord of Mouth oChemist
oOther, please specify: _____

Reminder Systems

Our practice provides our patients with preventive care and early disease detection reminders e.g. immunisations, annual health checks, skin checks, and cervical screening tests.

If we need to contact you what is your preferred method of contact:

o Home Phone o Mobile o Email o Mail

Patient Background

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

Do you identify as someone from a culturally and/or linguistically diverse background?

o Yes o No. Please elaborate:

Country of birth: Spoken Languages:

To assist with health initiatives – are you an Aboriginal or Torres Strait Islander?

Are you currently seeing an optometrist/ophthalmologist?
o Yes o No If yes, please state where: If yes, do you give consent to the clinic to obtain a copy of your records from your optometrist/ophthalmologist? o Yes o No

o No o Yes – Aboriginal o Yes - Torres Strait Islander o Yes – Aboriginal & Torres Strait Islander

Your Health History

Do you have or have you had a history of the following? (please elaborate)
o Operations:
o Asthma o Diabetes o Hypertension
o Other medical conditions:

Do you have any allergies or are you sensitive to drugs or dressings?
o Yes o No. Please Advise each Drug and the reaction: 1- 2- 3- 4- 5- 6-

Children's Immunisations

If completing this form for a child are their immunisations up to date?
o Yes o No

Current Medications

Please list all current medications including over the counter medications, vitamins and minerals:

Family History

Have any members of your family had: (please elaborate)
o Heart Disease oStroke o Asthma o Diabetes o Mental Illness o Cancer

Do you use any of the following: (list amount where appropriate)	
Tobacco	o No. o Yes. Number ____ day / ____ week **or** o Ceased smoking
Alcohol	o No. o Yes. Number ____ day / ____ week / ____ month
Drug Use	o No. o Yes. Type _____ / Frequency _____

Females

When did you last have?			
Cervical Screening Test	Date:	o Not sure	o Never
Breast Check	Date:	o Not sure	o Never

Health Information Collection and Use Consent Form *Lowndes Street Clinic*

As a patient of our medical practice 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.

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We aim to protect the privacy and secure storage of your health information. You can request a copy of our privacy policy, which includes information about the collection, use and disclosure of your health information.

We require your consent to collect personal information about you and to use the information you provide in the following ways. Please read this consent form carefully, and sign where indicated below.

- Administrative purposes in running our medical practice.
- Billing purposes, including compliance with Medicare and Services Australia requirements.
- Disclosure to others involved in your healthcare 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 referrals.
- Disclosure to other doctors in the practice, locums etc. attached to the practice for the purpose of patient care and teaching.
- For research and quality assurance activities to improve individual and community health care and practice management. Usually information that does not identify you is used but should information that will identify you be required you will be informed and given the opportunity to "opt out" of any involvement.
- To comply with any legislative or regulatory requirements, e.g. notifiable diseases.
- For reminder letters which may be sent to you regarding your health care and management.

You can decline to have your health information used in all or some of the ways outlined above, but it may influence our ability to manage your health care to provide the best outcome for you.

I have read the information above and understand the reasons why my information must be collected.	☐
I understand that I am not obliged to provide any information requested of me, but failure to do so may compromise the quality of health care and treatment given to me.	☐
I am aware of my rights to access the information collected about me, except in some circumstances where access may be legitimately withheld. I will be given an explanation in these circumstances.	☐
I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.	☐
I consent to the handling of my information by the practice for the purpose set out above, subject to any limitations on access or disclosure of which I notify this practice.	☐
OR	
I am unsure and would like to discuss this further with someone from the medical practice before I sign.	☐

We are a bulk billing clinic. Standard consultations are bulk billed for Medicare-eligible patients. Some services, such as Implanon and Dr Rajini Kajarajan's consultations, carry a fee, which our reception team will explain before your appointment.

☐

Patient's name: **……** Date: **……**

Patient's signature: **……**

Signed as Guardian for child: ……
Name: (printed) ……