CaligemHEALTH.com.au	New Patient Information Form

Title: ___ First name: _____ middle name: _____ last name: _____

Preferred name: _____ DoB: _____ Male/Female/Other(pls specify)_____

Country of Birth: _____ Aboriginal ☐ Torres Straight Island ☐ Registered for CTG ☐

Address: _____Suburb: _____State: _____Postcode: _____

Home Phone: _____ Work Phone: _____Mobile: _____

Medicare Number (10 digits) _____ Ref No. (left of name)_____Expiry Date: _____

Government concession number: _____ Expiry: _____ Pension ☐ Health Care Card ☐ DVA ☐

Health Insurance Fund: _____Number: _____Religion: _____

Your Occupation: _____

Next of Kin Name: _____

Phone: _____Alternate number: _____ Relationship: _____

Emergency Contact: same as Next of Kin ☐ if different: Name/address/ contact number:

Name:_____ Phone:_____Relationship: _____

Information exchange

I consent to Caligem Health sending and acquiring information as required from other medical facilities to aid in the care and management of my health and/or conditions.

Yes: ☐ **No:** ☐

I Certify that the above information given is true. I take full responsibility for the payment of any medical account at the time of consult.

Signature: _____ Date: _____

Please turn over

Allergies : Nil known ☐		
Drug/item	Reaction	Severity (mild/medium/severe)

Regular Medications and over counter supplements					
Medication	Strength	Frequency	Medication	Strength	Frequency

Consent for Care Plans: **Yes** ☐ **No** ☐

Consent for Health Assessments: **Yes** ☐ **No** ☐

Smoking Status:

☐ Non-smoker ☐ Ex-smoker. Past history: How many per day when you smoked: _____

Quit date: _____

☐ Current smoker. How many per day? _____

Alcohol consumption:

Do you drink? ☐ Yes ☐ No

How many days per week: _____ How many drinks per day: _____

Marital status:

☐ Single ☐ Married ☐ De Facto ☐ Separated ☐ Divorced ☐ Widowed

Do you have a carer? ☐ No ☐ Yes If yes: Carer Details: Name & phone: _____

Are you a carer? ☐ No ☐ Yes

Family History

Mother: (M) Father: (F) (Place M/F beside response)

☐ Diabetes___ ☐ Hypertension___ ☐ Stroke___ ☐ Depression___

☐ Heart disease___ ☐ Breast cancer___ ☐ Colon Cancer___ ☐ Other significant family history:

_____

_____

Regular Pharmacy: _____

Data entered by: (nurse initials) _____

CaligemHEALTH.com.au	**Consent and enrolment for electronic services**

The purpose of this form is to inform you and seek your consent to the use and disclosure of your personal information in regards to our reminders and notifications systems within our practice.

Caligem Health is committed to providing our patients with quality health care. As part of our commitment, we have implemented technology solutions to enable communications with our patients via SMS (mobile text messaging), and mobile applications.

In keeping with our obligations under Privacy Act 1988 (Cth) Australian Privacy Principles and under State and Territory health records legislation, we wish to inform you of the purposes for which we may use your personal information and how we may use and disclose your personal information. Please refer to our privacy policy or privacy statement http://www.caligemhealth.com.au/practice-policies/ for more information on the management of personal information (including health information) by our practice.

We may send you the following types of communication. I give consent for SMS message for the following options: (please tick approved box option)

1. ☐ **Appointment reminders** – notifications to remind you of upcoming appointment dates with the practice as well as allowing you to confirm your appointment.
2. ☐ **Clinical reminders** – notifications to remind you to contact the practice to arrange appointments for regular clinical check-ups, medical procedures, immunisations due.
3. ☐ **Clinical communications** – communications about your clinical care at the practice such as returned pathology results or clinical messages from the medical practitioner, and
4. ☐ **Health awareness** – communications to you in relation to general health care information and health care services provided by this general practice including notifications about changes to our clinic's opening hours, and information about health care services provided by this general practice.

We may use third party service providers (which may be located outside of this State or Territory) to assist us in sending you the above communications.

To the extent practicable, we will send you communications via your preferred contact method indicated below. However, you acknowledge and agree that, in the course of providing health care services to myself, the general practice may need to use and disclose my personal information as set out in this form.

Full Name: _____

Date of Birth: _____

Mobile: _____

_____ _____

Signature Date