# New Patient Details

saltwater MEDICAL
TRUST US TO CARE

**We warmly welcome you to our practice.** Please fill out this form prior to your first consultation.

All new patients are booked into a 40 minute slot for their first visit (Long Consultation). This allows your doctor time to take a thorough history and work through your health concern. Most new patient consults take 20-40 minutes, however, if yours takes less than 20, or more than 40 minutes, you will be billed accordingly. Consultations are billed according to the time taken with your doctor, or in some cases, the complexity of the procedure or service being provided. If you need to discuss mental health issues AND see the GP for another separate urgent medical issue, you may be charged an additional item number (2713). This is due to the way Medicare requires item numbers to documented and this may increase the overall consultation fee. However, once you receive Medicare rebates, your 'out-of-pocket' cost will still be the same as listed for a standard or long consultation. Please see our fee schedule or ask your doctor or reception staff for more details.

**DRUGS OF DEPENDENCE PRESCRIBING POLICY:** Our doctors will not prescribe Drugs of Dependence or Schedule 8 Drugs to new patients at their first appointment.

## SECTION 1 | PERSONAL DETAILS

**Title** **Family Name / Surname**

**Given Name** **Middle Name**

**Preferred Name** **Date of Birth** / /

**Gender** (please tick)

☐ Male ☐ Female ☐ Other

**Preferred Gender Pronouns**

☐ He/Him/His ☐ She/Her/Hers ☐ They/Them/Theirs

☐ Other (Please specify)

**Ethnicity** (please tick)

☐ Non-Indigenous/Australian ☐ Aboriginal

☐ Torres Strait Islander ☐ Aboriginal/Torres Strait Islander

☐ Other (Please specify)

**Residential Address**

State Postcode

**Home Phone** **Work Phone**

**Mobile Phone** **Preferred Contact Phone**

**Email Address**

**Postal Address** ☐ Use Residential Address

State Postcode

**Medicare Number** **Valid To** / **Ref.** Position #

(Photographic ID and a valid Medicare card MUST be sighted by our staff BEFORE your appointment)

**Do you hold a current Healthcare Card or Pension Card?**

☐ Centrelink Healthcare Card ☐ Pension Card

**Healthcare or Pension Card Number** **Expiry Date** /

**Your Occupation**

**Usual / preferred Doctor (if known)**

- ☐ **Dr Nicola Kettleton-Butler**
- ☐ **Dr Deborah Vercoulen**
- ☐ **Dr Katie Machin**
- ☐ **Dr Laura Christie**
- ☐ **Dr Christopher Wilson**
- ☐ **Dr Rick Allen**
- ☐ **Dr Lucy Crosland**
- ☐ **Dr Caitlin See**
- ☐ **Dr Martin Huynh**

**Next of Kin** (Emergency Contact)

**Relationship to Patient** **Phone**

**How did you hear about us? (Please tick all that apply)**

- ☐ **Previous patient from another medical centre**
- ☐ **Drive/walk past**
- ☐ **Online search**
- ☐ **Facebook/Instagram**
- ☐ **Word of mouth**
- ☐ **Local Pharmacy**
- ☐ **Other**

## SECTION 2 | NON-ATTENDANCE, LATE CANCELLATION & PUNCTUALITY POLICY

Your appointment time is booked and held especially for you. If you can't make it **we require at least four business hours' notice.** We are fully booked each day and resource our practice accordingly. Giving 4 business hours' notice of a cancellation allows us to offer your appointment to other patients on the waiting list. We confirm all appointments 24 hours before via SMS. Failure to attend a confirmed appointment without 4 business hours notice will incur a non-Medicare rebatable fee of $50. Repeated late or non-attendance will result in the inability to book further appointments for a patient or family group. **We run on time (barring medical emergencies), so your punctuality is required.** If you arrive unreasonably late (more than 5 minutes) for your appointment you will be asked to reschedule, as commencing your appointment late will make the doctor run late for patients booked after you in the doctor's list that day. A late cancellation fee may also apply.

**Please sign here to indicate your understanding and acceptance of the policy outlined above.**

**Signature** **Date** / /

**OFFICE USE ONLY:**

- ☐ Patient has signed page 1 & 3
- ☐ Cancellation Policy explained
- ☐ **Photo ID & Medicare card sighted**
- ☐ Ethnicity entered in BP
- ☐ BP Medicare Check
- ☐ BP HI-ID Check

**COMPLETED BY:..... DATE: / /**

**Patient Name:** _____

## SECTION 3 | SOCIAL & MEDICAL HISTORY

**Waist Circumference**
Your doctor to record waist measurement at the initial consultation on this form and in patient chart.

What is your height? ☐ What is your weight? ☐

**Marital Status** ☐ Single ☐ Married ☐ De-facto ☐ Widowed ☐ Separated

**Accommodation** ☐ Home Owner ☐ Rental ☐ Relatives Home ☐ Nursing Home ☐ Homeless ☐ Other

**Live with** ☐ Spouse ☐ Alone ☐ Relative/Parents ☐ Friend ☐ Other

**Do you have a carer?** ☐ Yes ☐ No Name & phone of carer:

**Please list any significant medical or surgical history**

**Current Medications**

**Allergies**

**Complementary Medications**
(e.g. Multivitamins, fish oil)

**Note for parents/carers of children - please ignore irrelevant questions (e.g. Smoking, alcohol)**

**Do you smoke?** ☐ Yes ☐ No If yes, how many cigarettes do you smoke per day? Year started?

**Past smoking history?** ☐ Nil ☐ Light ☐ Moderate ☐ Heavy Year stopped smoking

**Do you drink alcohol?** ☐ Yes ☐ No

If yes, how many standard drinks per day? How many days per week?

**Have you had a skin check before?** ☐ Yes ☐ No **If yes, when?**

Do you work / spend a lot of time outdoors? ☐ Yes ☐ No Do you have a family history of skin cancer? ☐ Yes ☐ No

**Family History** ☐ Unknown (e.g. Adopted) ☐ No significant family history

**Mother:** Still Alive ☐ Yes ☐ No If no, age at death Cause of death
☐ Diabetes ☐ High Blood Pressure ☐ Heart Attack ☐ Stroke ☐ Colon Cancer ☐ Depression
☐ Breast Cancer ☐ Other

**Father:** Still Alive ☐ Yes ☐ No If no, age at death Cause of death

☐ Diabetes ☐ High Blood Pressure ☐ Heart Attack ☐ Stroke ☐ Colon Cancer ☐ Depression
☐ Prostate Cancer ☐ Other

**Female Patients: Are you pregnant?** ☐ Yes ☐ No **Have you had a pap smear?** ☐ Yes ☐ No Month/Year

**Are you breast feeding?** ☐ Yes ☐ No **Have you ever had a mammogram?** ☐ Yes ☐ No Month/Year

**Patient Name:** _____

**Other immediate family member's significant medical history (please specify)**

**Is there anything else you would like us to know?**

## SECTION 5 | PARENTING DETAILS (Fill out this section if the new patient is a child)

**Are there currently any court orders in place around custody of this child?** ☐ Yes ☐ No
If yes, please provide a brief summary:

To ensure the best protection of the child, we may ask you to provide evidence of court orders, agreements or parenting plans.
It is your responsibility to inform us if authorisation for an individual is to be revoked or changed.

Your Privacy. We take the privacy of your personal information very seriously. We are collecting this information in order to provide you with high quality health services. We understand the personal and sensitive nature of the information you are providing to us and will safeguard your privacy in strict accordance with the Privacy Act (1988). If you would like to obtain a copy of our privacy policy or have any questions or concerns, please see our reception staff or our Practice Manager.

## SECTION 6 | CONSENT

- I consent to the use of my personal health information by Saltwater Medical and other health care providers involved in my medical treatment and healthcare within this medical centre.
- I consent to the disclosure of my personal health information by Saltwater Medical to other health care providers (external to Saltwater Medical) who are involved in my personal health care or medical treatment (e.g. Specialists, Hospital Services, Allied Health, Pathology, Imaging etc.).
- I consent to receiving reminders, recalls, and appointment confirmations relating to me/my child via SMS, phone call or letter to the contact details listed on this form.
- I consent to Saltwater Medical providing de-identified statistical health information relating to me/my child for the purposes of research and quality assurance activities. Please be assured that your personal details such as name, address and date of birth are NOT disclosed.
- I understand it is my responsibility to inform Saltwater Medical if I have changed address or contact details, have received an updated Medicare card, or if custody arrangements or my health status has changed.
- I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.
- I consent to having a third party (e.g. interpreter or support person) present if required by me in consultations with the doctor.
- I have read the information above and understand the reasons why my personal information is being collected. I understand this practice has a privacy policy on handling patients' information and that I am not obliged to provide any of the information requested, but that failure to do so might compromise the quality of healthcare and treatment provided to me.
- I understand that Saltwater Medical will not contact me after I have been for a test or scan if the result was normal, and that the only time I will be contacted after a test or scan is when there is an abnormal result. I understand that it is my responsibility to arrange a follow up appointment after a test or scan if I am still experiencing symptoms or issues.

**Signature** _____ **Date** / /

Some things deserve more time and attention. *We believe your health is one of them.*

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Time Care Experience