Balance! Edmonton Family Practice

Welcome to Balance! Edmonton Family Practice. To ensure we have your current details, would you please complete the following questions and return this form to reception.

The Patients Details

Mr☐ Mrs☐ Ms☐ Miss☐ Master☐

Given Name: _____ Last Name: _____

Date of Birth: _____ /_____ /_____

Address: _____ Suburb: _____ State: _____ Postcode: _____

Postal Address: _____ Suburb: _____ State: _____ Postcode: _____

Telephone: Home: _____ Work: _____ Mob: _____

Email:_____Occupation:_____

Ethnicity (e.g. Australian, Italian, Japanese ETC): _____

Please circle if you are of any of the following:

Aboriginal / Torres Strait Islander / Aboriginal & Torres Strait Islander

Please be advised you may be required to provide proof or Confirmation of Aboriginality and/or Torres Strait Islander when applying for indigenous-specific services or programs provided by our practice.

The making of false or misleading claims could be considered as fraudulent and is punishable under the Criminal Code Act 1995.

Medicare Card:

Number: _____Ref: _____ (next to patient name) Expiry Date: _____ /_____

Concession Card:

Pensioner / Health Care Card / None (Circle)

Concession Card Number: _____ Expiry Date: ____ / ____/ ____

Dept of Veterans Affairs:

Card Number: _____ Gold / White (Circle)

Condition (DVA White card):_____

Private Health Insurance Fund: _____ Member Number: _____

Are there any legal or parenting orders in place? **Yes** or **No**

If yes, please provide a copy of the current order to reception.

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Next of Kin

Name:_____ Phone:_____ Relationship:_____

Emergency Contact (if different to next of kin contact)

Name:_____ Phone:_____ Relationship:_____

ALLERGIES

☐ No Allergies
☐ Allergic to _____

Reaction _____

Severity ☐ Mild ☐ Moderate ☐ Severe

Medications

Medications – Name	Dosage	Frequency

Medical Conditions

	Nil	Current	Past History
Asthma	☐	☐	☐
Diabetes T1	☐	☐	☐
Diabetes T2	☐	☐	☐
Heart Disease	☐	☐	☐
HIV/AIDS	☐	☐	☐
Hepatitis B/C	☐	☐	☐
Cancer	☐	☐	☐

Type of Cancer _____

Other _____

Past Medical and surgical history

Year	Condition	Year	Condition

Lifestyle Factors:

Current Smoking history:

Do you smoke? ☐ Yes ☐ No
How many cigarettes per day: _____
Year started: _____
Year ceased: _____

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Do you drink Alcohol? _____ ☐ Non- Drinker

How many standard drinks per day _____ or How many standard drinks per week _____

Do you play any elite sports? _____

Mother alive? Age of death: ___ Cause of death: _____

Father alive? Age of death: ___ Cause of death: _____

Significant family history

Mother:

- ☐ Diabetes
- ☐ Hypertension
- ☐ Heart disease
- ☐ Stroke
- ☐ Cancer
- ☐ Depression
- ☐ Breast cancer

Father:

- ☐ Diabetes
- ☐ Hypertension
- ☐ Heart disease
- ☐ Stroke
- ☐ Cancer
- ☐ Depression

Marital status:

- ☐ Single
- ☐ Married
- ☐ Widowed
- ☐ De facto
- ☐ Separated
- ☐ Divorced

Sexuality:

- ☐ Heterosexual (Opposite sex)
- ☐ Homosexual (Same sex)
- ☐ Bisexual (Both opposite & same sex)

Accommodation:

- ☐ Own home
- ☐ Relative home
- ☐ Nursing home
- ☐ Other private housing
- ☐ Rental home
- ☐ Hostel
- ☐ Homeless

Lives with:

- ☐ Spouse
- ☐ Friend
- ☐ Relative
- ☐ Care
- ☐ Alone

Do you have a Carer? Yes_____ No ___

Carer Details:

Name:_____

Address:_____

Phone number: _____

Relationship: _____

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New patient enrolment

Fees

At Balance! Edmonton Family Medical Centre, we are a private billing practice. Consultation Fees are payable at time of consultation. All Healthcare Card, Pension Card Holders, DVA card holder, Aboriginal and Torres strait Islanders and children under 16 Years will be Bulk Billed.

By signing the below, you (as a patient/ guardian) are knowledge that Balance! Edmonton Family medical centre is a private billing practice.

Signature: _____ Date: ____/____/____

Privacy

To enable ongoing care and total quality improvement within this practice, and in keeping with the Privacy Act and 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.

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:

- For use when seeking treatment by other health professionals in this practice.
- Follow up reminder/ recall notices by letter or telephone (including contact via SMS to your mobile phone number) for treatment and preventative healthcare.
- For accounting procedures and the collation of professional fees.
- The diagnosis and treatment of any health condition, including the communication of information to practice staff, specialists and other healthcare providers to ensure quality care is provided.
- For legal related disclosure as required by a court of law.
- For the purposes of research only where de-identified information is used.
- General practice accreditation and quality assurance activities.
- To allow medical students and authorised staff to participate in medical training/ teaching.
- For disease notification as required by law.

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.

You may request a copy of our Privacy Policy from reception

I, _____ give my permission for my personal health information to be collected, used and disclosed as described 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 or restrict ant anytime by notifying this practice in writing. I agree to be contacted to participate in preventative health actions considered appropriate by Balance! Edmonton Family Practice General Practitioners.

Signature: _____ Date: ____/____/____

How did you hear about this practice? _____