



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

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)

Conditions (DVA White card): _____

Private Health Insurance Fund: _____ Member Number: _____

Next of Kin

Name: _____ Phone: _____ Relationship: _____

Emergency 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes T1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes T2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B/C	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Type of Cancer	_____		
Other	_____		

Past Medical and surgical history

Year	Condition	Year	Condition

Lifestyle Factors:

Do you smoke? Yes / No Ex-smoker Year you ceased: _____

Cigarettes/Tobacco per day _____

Do you drink Alcohol? Yes / No

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

Fees

Balance! Springwood Family Practice is a private billing practice. Consultation Fees are payable at time of consultation by Eftpos, Cash or Cheque. 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 acknowledging that Balance! Springwood Family Practice 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! Springwood Family Practice General Practitioners.

Signature: _____ Date: ____/____/____

How did you hear about this practice? _____