NEW PATIENT MEDICAL FORM

access cardiology

PATIENT DETAILS

*Please print clearly. Name to be written as recorded with Medicare.

Title: _____ First Name: _____ Surname: _____

Date of Birth: _____

Address: _____

Suburb: _____ State: _____ Postcode: _____

Home Phone: _____ Work Phone: _____ Mobile: _____

Email: _____

Medicare Number: _ _ _ _ _ _ _ _ _ _ Expiry Date: ___/___ Individual Reference #: (Found to the left of your name) _____

Pension & Health Care Card CRN: _____

Private Health Fund Name: _____ Health Fund Number: _____

Dept. Veteran Affairs: White: ☐ Gold: ☐ DVA Number: _____

General Practitioner Name: _____ Medical Centre: _____

Other Interested Parties: _____

NEXT OF KIN

First & Surname: _____ Relationship to you: _____

Contact Telephone Number: _____

HEALTH INITIATIVES – In order for us to tailor optimal & appropriate medical care

- Do you identify yourself as Aboriginal? Y ☐ N ☐
- Do you identify yourself as Torres Strait Islander? Y ☐ N ☐
- Do you have Hypertension? (High blood pressure) Y ☐ N ☐
- Do you have Abnormal Cholesterol? (Triglycerides) Y ☐ N ☐
- Do you have a bleeding problem / disorder? Y ☐ N ☐
- Do you have Diabetes? Y ☐ N ☐
- Do you have kidney problems? Y ☐ N ☐
- Do you have Peripheral Artery Disease? (Legs/Carotids) Y ☐ N ☐
- Do you smoke? Y ☐ N ☐
- Do you drink alcohol? Y ☐ N ☐

If yes how often? _____ If yes how often? _____

- **Does your family have any history of heart conditions?** Y ☐ N ☐

If so, please provide details: _____

- **Has anyone in your family had an angioplasty (heart artery stent)?** Y ☐ N ☐

If so, please provide details: _____

- **Do you have a Pacemaker?** Y ☐ N ☐

If so, when was it installed? What brand do you have? _____

- **Do you have a Biventricular Pacemaker?** Y ☐ N ☐

If so, when was it installed? What brand do you have? _____

- **Do you have an ICD (Implantable Cardiac Defibrillator)?** Y ☐ N ☐

If so, when was it installed? What brand do you have? _____

- **Do you have a Loop Recorder?** Y ☐ N ☐

If so, when was it installed? What brand do you have? _____

- **Do you suffer from leg swelling or do you have aches in your calves when walking?** Y ☐ N ☐

Please explain: _____

- **Are you on any medication?** Y ☐ N ☐

List all the medications (unless on referral) you are taking including all prescription & non-prescription medications.

PATIENT CONSENT TO COLLECT & DISCLOSE INFORMATION

The Privacy Act of 1988 requires all health practitioners to obtain consent from their patients to collect, use and disclose patients' information.

COLLECTION

Access Cardiology staff will collect information that is necessary for your treatment. Such necessary information may include:

- Full medical and psychological history.
- Family medical and psychological history.
- Ethnicity.
- Medicare / Private health fund details.
- Billing and accounting information.
- Contact Details.

The information will normally be collected directly from you; however, there may be occasions when it will be necessary to collect information from other sources with your prior consent. These sources may include but are not limited to:

- Parents about children.
- Children about their family.
- Schools and teachers.
- Other health care providers.

In emergency situations we may have to collect information from relatives or other sources without your prior consent.

USE AND DISCLOSURE

With your consent we will use and disclose your information for purposes such as:

- Account keeping and billing.
- To reply to your referring doctor.
- Referral to another health care provider or hospital.
- Management of Access Cardiology including quality assurance, practice accreditations and complaint handling.
- To prevent or lessen a serious threat to an individual's life, health or safety.
- Where legally required to do so e.g. by a court, mandatory reporting etc.
- To meet our obligations of notification to medical defence organisations or insurer.

ACCESS

Do you give consent to be contacted via email & SMS (mobile text message) for: appointment reminders, recall and other text reminders or medical services we offer? Y ☐ N ☐

You are entitled to have access to your own health records at any time convenient to all parties. Depending on the nature of the access requested a charge might be payable where the practice incurs costs in providing access. There are some circumstances in which access may be denied, but in such an event you will be advised of the reason. If you find any information we hold on you is inaccurate or incomplete, please advise us so that we can adjust your record. We are not able to erase the original record.

Patient Signature: _____ Date: _____