adelaidedisability medical services

New Patient Form

PATIENT INFORMATION – Ensure all sections are completed in its entirety

Title: _____ Family Name: _____ Given Name: _____

Middle Name: _____ Preferred Name: _____ DOB: _____

Gender: ☐ M ☐ F ATSI: ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ None Ethnicity: _____

Medicare Card No: _____ IRN: _____ Expiry Date: _____

Pension Card No: _____ Expiry Date: _____

Pension Card Type: ☐ Pensioner Concession ☐ Health Care Card ☐ Commonwealth Seniors

Address: _____ Postcode: _____

Housing Type: ☐ Living with Family as Support

☐ Supported Residential Facilities, Organisation: _____

Home Phone: _____ Work Phone: _____ Mobile: _____

Next of Kin: _____ Relationship: _____ Mobile: _____

Emergency Contact: _____ Relationship: _____ Mobile: _____

Email Address 1: _____ (For general correspondence)

Email Address 2: _____ (For invoices)

DETAILS ABOUT YOU

☐ Acquired Brain Injury ☐ Intellectual Disability ☐ Down Syndrome ☐ Autism

☐ Tuberous Sclerosis ☐ Cerebral Palsy ☐ Fragile X Syndrome ☐ Physical, provide details

☐ Other, provide details _____

Any relevant medical family history:

_____

_____

Do you have any mobility considerations? _____

Name of Current GP & Practice: _____

Are there any safety concerns regarding the patient or towards staff that we should be aware of:

☐ No ☐ Yes, please advise: _____

SMOKING STATUS/ALCOHOL STATUS

☐ Smoker ☐ ExSmoker ☐ Non-Smoker ☐ Non-Drinker ☐ Drinker Drinks per day_____

Smokes per day_____ ☐ Social Drinker Days per week_____

Medical Record Privacy Statement

In accord with the Australian Privacy Principles (APPs) contained in the Privacy Act 1988, all health information collected, used, disclosed and stored at this practice is treated with the highest standards possible to make sure that your privacy is maintained. We request your consent to collect and use personal information about you. Please read this page carefully, and sign where indicated below. This medical practice maintains information which we obtain from you, in your medical record, for the purpose of providing quality health care. We request that you provide us with your personal details and a full medical history so that we may properly assess, diagnose and treat you and be proactive in your health care needs. To do this we may need to use the information you provide in the following ways:

- administrative purposes in running this medical practice
- billing purposes, including compliance with Medicare Australia requirements
- disclosure to others involved in your health care: this may occur through referral to other health care providers or referral for medical tests and scans
- disclosure to other doctors, including doctors and specialists treating you outside this medical practice, to enable proper patient care
- involvement in quality assurance activities known as clinical audits or research during which information from your records may be used in such a way that it does not identify you and cannot be traced to you in any way.
- From time to time we may want to send you reminder letters concerning routine test.

Your medical record is a confidential document. It is the policy of this practice to maintain security of personal health information at all times and to ensure that this information is only available to authorised members of staff.

A copy of our full privacy policy is available on request.

I have read the information above and understand the reasons why information about me may be collected. I am also aware that this practice has a privacy policy on handling patient information.

I understand that I am not obliged to provide any information requested of me, but that my failure to do so may possibly compromise the quality of the health care and treatment given to me.

I am aware of my right to access the information collected about me.

I understand that if information about me is to be used for any other purpose, other than set out above, my further consent will be obtained.

I consent to the use of information about me by Adelaide Disability Medical Services for the purpose(s) set out above, subject to any limitations on access or disclosure that I notify this practice of.

Further information about privacy rights can be obtained from:

Office of the Australian Information Commissioner
GPO Box 5218
Sydney NSW 2001
Telephone: 1300.363.992
Email: enquiries@oaic.gov.au

If this form is completed by a supervisor/staff member,

- is the legal guardian/patient aware of this application? ☐YES ☐NO
- has the legal guardian/patient signed the Medical Record Privacy Statement? ☐YES ☐NO
- is the legal guardian/patient aware that ADMS charges a gap fee for certain appointments? ☐YES ☐NO

If any of the answer is no, please discuss with the legal guardian/patient before submitting the form. ***Thank you for your application. We will only be in touch if the patient is accepted based on the clinic's capacity.***

Signature: _____

Date: _____

Print Full Name: _____ **Please circle: Patient / Guardian**

Relationship To Patient: _____