BELLINGEN HEALING CENTRE

18 William Street
Bellingen NSW 2454
Phone: 6655 0000
Fax: 6655 0266
ABN 35 616 896 074
bhc@bellingenhealingcentre.com.au
www.bellingenhealingcentre.com.au

Patient Information & Medical History

Nurse/Doctor appointment

Name of patient: **Mr Mrs Ms Miss** _____ _____
First Name *Surname*

Current Address: _____

Date of Birth: __ __ / __ __ / __ __ __ __ **Gender:** ☐ Male ☐ Female ☐ (Indeterminate/Intersex/Unspecified)

Phone/Email Details: Home: _____ Work: _____

Mobile: _____ Email: _____

Can we send SMS reminders ☐ No ☐ Yes

Medicare Card Number: __ __ __ __ __ __ __ __ __ __ Ref Number: __ **Expiry** Date: __ __ / __ __ __ __

Pension Card: ☐ No ☐ Yes__ __ __ __ __ __ __ __ __ __ Expiry Date: __ __ / __ __ / __ __ __ __

Health Care Card: ☐ No ☐ Yes__ __ __ __ __ __ __ __ __ __ Expiry Date: __ __ / __ __ / __ __ __ __

DVA Card: ☐ No ☐ Yes__ __ __ __ __ __ __ __ __ __ DVA Colour: ☐ White ☐ Gold ☐ Orange

Indigenous Status: ☐ N/A ☐ Aboriginal ☐ Torres Strait Islander: Registered For Closing The Gap: ☐ Y ☐ N

Country of Birth: Ethnicity _____ **Primary Language:** _____

Occupation: _____

Emergency Contact NOK Name: _____ DOB: _____

Alternate Phone: _____ Relationship to you: _____

Occupation: _____

Bellingen Healing Centre promotes a policy of **ZERO TOLERANCE** toward workplace violence, including but not limited to: physical assault, threatening behaviour, obscene phone calls or verbal abuse. If you are unable to do this then we have no alternative other than to cease our clinical service to you.
Please be aware that if you do not give a min of 2hrs notice that you will not be attending your appointment, a no show fee will be charged.
I understand and agree to abide by the above policy & fees, and that non-compliance may result in the cessation of care at this practice or a fee being incurred.

Signature (adult): _____ Date: _____

Signed as Guardian of child (child's name): _____ Date: _____

Guardian's Name (printed): _____ DOB: _____

MEDICAL HISTORY

Have you or your child ever had any of the following:

Operations: Details: _____ Date: _____

Details: _____ Date: _____

Details: _____ Date: _____

Details: _____ Date: _____

Asthma: ☐ No ☐ Yes

Diabetes: ☐ No ☐ Yes

Hypertension: ☐ No ☐ Yes

Chronic illness: ☐ No ☐ Yes Details: _____

Known Allergies: ☐ No ☐ Yes Details: _____

Other Health Conditions: Details: _____

_____

_____

CURRENT MEDICATIONS _____

FAMILY HISTORY: Please provide a short family health history of the following family members who may have

Diabetes **Asthma** **Heart Disease** **Cancer**

Mental Illness: *Please outline any mental health issues in your family e.g. anxiety, depression, bi-polar, schizophrenia etc.*

☐ Father _____

☐ Mother _____

☐ Siblings _____

☐ Your Children _____

☐ Grandparents _____

☐ Aunts,Uncles,Cousins _____

Children's Immunisations If completing this form for a child, are their immunisations up to date? ☐ No ☐ Yes

Childs current medications (including over the counter medications, vitamins and minerals): _____

_____

Social history:

☐ I have never smoked ☐ Ceased Smoking ____ / ____ / ____: ☐ Currently Smoke _____ per day

☐ I do not drink alcohol _____drinks per day /week/month If more than 6 drinks per day, how often? _____

☐ Recreational drug use: _____ (type and frequency)

Height if known: _____ cms **Weight** if known: _____ kgs **Waist Measurement** if known: _____ cms

Blood Pressure if known: ____ / ____ last time your blood pressure was taken? ___ / ___ / ____

How often do you exercise or engage in physical activity for 30 minutes or more?

☐ Daily ☐ ____times per Week ☐ never ☐ other: _____

Females - When did you last have a:

Pap smear	Date: _____	☐ Not Sure	☐Never
Breast Check	Date: _____	☐ Not Sure	☐Never
Mammogram	Date: _____	☐ Not Sure	☐Never

Males - When did you last have an overall check up Date: _____ ☐ Not Sure ☐Never

For those 65 years and older: When was the last time you were immunised for

Influenza (Flu Shot) Date: _____ ☐ Not Sure ☐Never

Pneumococcal Pneumonia Date: _____ ☐ Not Sure ☐Never

Is there any other information that you believe we should know that may affect / or have an influence on the medical treatment / advice you or your child will be provided with?

If **yes**, please provide details below -

_____

_____

Signature (adult): ..... Date: .....

Signed as Guardian of Child (child's name):.....

Guardian's Name (printed):..... DOB .....

Collection of Personal Information, Privacy Act 1988 (Cth) and HRIP Act 2002 (NSW)

Bellingen Healing Centre collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may properly assist, diagnose and treat illnesses and be pro-active in your health care. We will also use the information you provide in the following ways:

- Administrative purposes in running our medical practice
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements
- Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice
- Disclosure for research and quality assurance activities to improve individual and community health care as well as practice management.

You will be informed when such activities are being conducted and given the opportunity to opt-out of any involvement.

I have read the information above and understand the reasons why my information must be collected. I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to me.

I am also aware that this practice has a privacy policy, which contains information about accessing and seeking correction of personal information, as well as the privacy complaints handling process.

I am aware of my right to access the information collected about me, except in circumstances where access might be legitimately withheld. I understand I will be given an explanation in these circumstances. I understand that if I request access to information about me, the practice will be entitled to charge fees to cover time and administrative costs which may not be covered by a Medicare rebate.

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

I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure that I notify this practice of.

Signature (adult): _____ Date: _____

Signed as Guardian for child: (child's name).....
Guardian's Name: (printed) .....
Guardian's DOB: .....

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Consent/Request for Health Records and Information

Changes to the Privacy Laws now means that a person or guardian's written consent is required for health professionals to request and obtain medical information concerning that person or to communicate medical information about that person to other practitioners. For Bellingen Healing Centre to request medical information required for your ongoing care and to liaise with other practitioners we need you to sign this form.

I, _____ DOB _____

Medicare Number_____

Hereby give my permission for the doctors at Bellingen Healing Centre to
1. Obtain medical information about previous consultations, results of investigations and details of past treatment from government departments, other medical practitioners, hospitals and health care providers that relates to my medical condition.
2. Communicate with medical practitioners, hospitals, health care providers and other health professionals concerning my medical condition.

Patient's name:…… **Date:** ……
Signature (adult):……

Signed as Guardian for child: ……
Guardian's Name: (printed) ……
Guardian's DOB: ……

Bellingen Healing Centre will use this consent on an ongoing basis to collect information relevant to your health care. If you wish at any stage to withdraw your consent please inform us of your decision in writing.

Kind Regard,
Bellingen Healing Centre

Practice Request for Patient Records

To: Previous Dr Practice _____ Fax: _____

Address:_____

The above named patient/s are now attending Bellingen Healing Centre for ongoing health care; please supply patient health information **IN PDF** (we are unable to read XML) in the follow specific format:

☐ Accurate summary ☐ Full copy of Health Information ☐ Please provide copy of current plan

Date of last:

721 _____ MHP_____
723 _____ 732 _____
732 _____