NEW PATIENT INFORMATION SHEET

Circle: Miss/Ms/Mrs Surname:_____ Maiden or other names: _____

First Name:_____ Middle Name:_____ Date of Birth:_____

Full Name of Parent (for minors only)_____

Ethnicity & Country of Birth _____ Indigenous Status: Aboriginal TSI Neither

Street Address:_____ Suburb:_____

Post Code:_____ Email Address: _____

Home Phone:_____ Work Phone:_____ Mobile Phone:_____

Occupation:_____ Marital Status:_____ Permission: SMS Y ◯ N ◯ Email Y ◯ N ◯

Emergency Contact: _____Relationship:_____ Phone: _____

Medicare Number:_____ Ref #_____ Expires:_____

Hospital Health Fund:_____ Membership Number:_____ Ref #___

Referring Doctor or Hospital:_____

General Practitioner (if not referring doctor):_____

Address:_____ Suburb:_____

Post Code:_____ Phone Number:_____

How did you hear about Dr Bailey/Dr Thomas? _____

Have you received treatment from Dr Bailey/Dr. Thomas previously? ☐ YES ☐ NO

Where:_____

Correspondence will usually be sent to the referring doctor and your GP

Are you agreeable to this? ☐ YES ☐ NO

Signature:_____Date:_____

All fees are requested at the time of consultation with Dr Bailey.
Thank you for your cooperation in this matter.

HUNTER WOMEN'S HEALTH CENTRE

Obstetrics & Gynaecology
119 Pacific Highway, Charlestown, NSW 2290
Phone: 4959-3883 Fax: 4959-8335
E: info@hunterwomens.com.au

HEALTH HISTORY

Name: _____ Date: _____ **Age:** _____ Birthdate: _____

Referred by: _____

What is the main problem today that brings you in for a visit?

_____

_____

Obstetric History

How many times have you been pregnant? _____

Please complete date of pregnancy / delivery method

1. Date _____ Delivery Method _____
2. Date _____ Delivery Method _____
3. Date _____ Delivery Method _____
4. Date _____ Delivery Method _____
5. Date _____ Delivery Method _____
6. Date _____ Delivery Method _____

Additional Information: _____

Menstrual History

Age menstruation started: _____ When was the first day of your last menstrual period? _____

How frequent do your periods occur? _____

How long do they last? _____

Do you need to use any pain medications? ☐ **YES** ☐ **NO**

If so, what do you use? _____ Do you have any bleeding after sex? ☐ **YES** ☐ **NO**

Do you have bleeding or spotting between your periods? ☐ **YES** ☐ **NO**

Current birth control method: _____

When was your last Cervical Screening Test (formerly Pap Smear)? _____ Was it normal? ☐ **YES** ☐ **NO**

Have you ever had an abnormal CST (Pap smear)? ☐ **YES** ☐ **NO**

If so, when? _____ How was it treated? _____

When was your last mammogram? _____ Was it normal? ☐ **YES** ☐ **NO**

Have you ever had an abnormal mammogram? ☐ **YES** ☐ **NO**

If so, how was it managed? _____

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HEALTH HISTORY

Sexual History

Are you currently sexually active? ☐ **YES** ☐ **NO**

Do you have pain during or after intercourse? ☐ **YES** ☐ **NO**

Number of partners (in the last year) _____ (in your lifetime) _____

Sexual Orientation _____ Have you ever had a sexually transmitted infection

☐ **YES** ☐ **NO** If so, when? _____ How was it treated? _____

Past Medical History (List all medical illnesses such as asthma, diabetes, high blood pressure etc.):_____

_____

_____

Past Surgical History (List all of the operations you have had such as cesarean section, tonsillectomy ect.)

_____

_____

_____

Family History List history for grandparents, parents, siblings and children.

☐ **YES** ☐ **NO** Breast Cancer
☐ **YES** ☐ **NO** Ovarian Cancer
☐ **YES** ☐ **NO** Colon Cancer
☐ **YES** ☐ **NO** Other Cancers
☐ **YES** ☐ **NO** Osteoporosis

☐ **YES** ☐ **NO** Heart Disease
☐ **YES** ☐ **NO** Stroke
☐ **YES** ☐ **NO** Clotting Disorders
☐ **YES** ☐ **NO** Inherited Disorders
Other: _____

Social History

Tobacco use: ☐ **YES** ☐ **NO** packs per day: _____number of years: _____

Alcohol use: ☐ **YES** ☐ **NO** Street drug use ☐ **YES** ☐ **NO**

Level of Education _____ Exercise (frequency and type): _____

Are you currently or have you ever been in a relationship where you have been or are physically hurt, threatened or made to feel afraid? ☐ **YES** ☐ **NO**

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HEALTH HISTORY

Medications / Dose / Frequency

_____

_____

_____

Allergies and Reactions (List allergies to all medications, foods, etc)

_____

_____

_____

_____

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Informed Financial Consent

This document provides general information regarding fees for procedures that occur at Newcastle Private Hospital or Lake Macquarie Private Hospital. Our surgeons fees for hospital procedures are set to no more than 80% of the Australian Medical Association's (AMA) fees, which means that the fee is at least 20% less than that recommended by the AMA.

Surgeon Fees

Our surgeons charge a gap fee for your procedure between $250-$500 that is due at the time of surgery booking, if you are in a private health fund.

If self-funding, you will be required to make the proposed Total Fee Payment no later than 48hrs prior to your upcoming surgery. If the Total Fee Payment is made at least seven days prior to your procedure, you will receive a 10% discount on the Total Fee Payment. Once the surgery has been completed, the invoice will be electronically sent to Medicare so that your eligible rebate can directly return to your nominated Medicare account.

PLEASE NOTE

Our estimates are estimates ONLY. On occasion your surgery may be more or less complex than expected, which means that the Total Fee Payment will change. If we owe you money, we will return it to the bank account of your choice.
If you owe HWHC additional funds, we appreciate your prompt payment of these funds.

Anaesthetist Fees

Your anaesthetists may also charge a gap fee, if you are in a private health fund. You can call the number on your quote to obtain their fees.

If self-funding you will need to contact the anaesthetist listed on your Estimate of Medical Fees to obtain a quote for their portion of your service. There is usually a Medicare rebate for anaesthetic services.

Private Hospital Fund

If you are in a private health fund you will be charged an excess as noted on your personal policy. This charge is usually $0-$750. The hospital will bill you for this when you book into the hospital.

If self-funding you will need to contact the hospital listed on your Estimate of Medical Fees to obtain a quote for their portion of your service.

Other Fees

You may also receive a bill for any pathology or radiology services that are performed while you are at the hospital.

Printed Name _____

Signature _____ Date _____

PATIENT CONSENT TO COLLECT AND DISCLOSE INFORMATION

The Privacy Act 1988, as amended by The Privacy Amendment (Private Sector) Act 2000, requires medical practitioners to obtain consent from their patients to collect, use and disclose a patient's personal information.

Please read this information carefully and sign where indicated below.

We require you to provide us with your personal details and a full medical history so that you can be properly assessed and treated. The information supplied will be used in the following ways:

- Administrative and billing purposes in running the medical practice, including compliance with Medicare and Health Insurance Commission requirements.

- Disclosure to others involved in your healthcare, including treating doctors, specialists and physiotherapists outside this medical practice. This may occur through referral to other doctors or for medical tests and in the reports or results returned to us following the referrals.

Both our practice staff and specialists may participate in the collection of this information.

In emergency situations we may need to collect personal information from relatives or other sources where we are unable to obtain your prior express consent.

HWHC will obtain a facial photograph to be included in your medical record. We also use CCTV to help provide security for you.

Privacy is of utmost importance to HWHC and to that end we take care to maintain your privacy with, but not limited to, CCTV, cyber security, emails, SMS and social media.

I have read the information above and understand the reasons why my information must 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 might compromise the quality of the healthcare and treatment given to me.

I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand that I will be given an explanation in these circumstances. *(It is likely that you will be asked to contribute to the cost of providing this information.)*

I understand that if my information is 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 in writing.

Print Name:	DOB:
Signed:	Date:

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