

New Patient Application Form

All new patients will be required to complete and return this paperwork before they can make an appointment at Mudgee Medical Centre

Note: please allow up to 1 week for your application to be processed. You will only be notified if your application is rejected or further information is required. It is important to note that you don't have to make an appointment if you don't need one. Most of our existing doctors have closed their books to new patients so you will be offered an appointment with one of our new doctors.

Do you reside in the 2850 postcode?

Yes No

If No: unfortunately we cannot accept you as a new patient unless you fit the criteria below under Exceptions

If yes:

You **must** provide proof that you reside in the 2850 postcode e.g. driver's licence, rates notice, electricity account etc.(children under 18 years of age can use their parent's proof of residency):

Document shown as proof of residency: _____

MMC staff to tick the box & sign: document sighted Yes No _____

Staff signature required

If yes to residing in the 2850 postcode:

Are you currently seeing a doctor at South Mudgee Surgery?

If yes: unfortunately we cannot accept you as a new patient unless you fit the criteria below under Exceptions

Yes No

If yes to residing in the 2850 postcode:

Are you currently seeing a doctor at Gulgong Medical Centre?

If yes:

Please record the reason that you wish to be a new patient at Mudgee Medical Centre.

Yes No

Reason:

If yes to residing in the 2850 postcode:

Have you registered for My Medicare at another practice?

If yes:

Please record the name of the practice where you are registered.

Yes No Unsure

Exceptions (please tick the appropriate box if requesting an exception)

- New health professionals working in the Mid-Western Regional Council area and their immediate family members. Yes
Record Occupation and Employment details: _____
- People requiring antenatal (pregnancy) or pregnancy planning consultations. Yes
- Pre-op anaesthetic assessment with Dr Kennedy only (however this does not mean that Mudgee Medical Centre can see you for future care if you don't fit the above criteria). Yes
- Hepatitis A and B Screening and vaccination, Q Fever vaccination with Dr Geoffrey Bennett & Dr Tommy Tan (however this does not mean that Mudgee Medical Centre can see you for future care if you don't fit the above criteria). Yes
- Yellow Fever vaccination with Dr Geoffrey Bennett (however this does not mean that Mudgee Medical Centre can see them for future care if they don't fit the above criteria). Yes
- IUD Mirena bookings with Dr Peter Bryant, Dr Geoffrey Bennett and Dr Edward Lee (however this does not mean that Mudgee Medical Centre can see you for future care if you don't fit the above criteria). Yes
- Skin checks with Dr Tony Egan (however this does not mean that Mudgee Medical Centre can see you for future care if you don't fit the above criteria). Yes

Personal Details – This information will be scanned into your medical file after it is used to create your medical record at Mudgee Medical Centre.

Title:		Surname:				
Given name:		Middle Name:				
Preferred name:						
Date of Birth:		Birth Sex:				
Gender Identity:	Female	Male	Non-binary	Gender diverse	Transgender	Different identity
Pronouns:	She / Her / Hers		He / Him / His		They / Them / Theirs	

Cultural background – *knowing your cultural background can help us provide healthcare that meets your individual needs*

Ethnicity:	Australian, non-indigenous	Aboriginal but not Torres Strait Islander	Torres Strait Islander but not Aboriginal
	Both Aboriginal and Torres Strait Islander	Other:	
Your country of birth:			
Preferred Language	English	Other language:	
Do you require an interpreter service?	Yes or No:		

Contact Details

Home Address:			
Postal Address:			
Home phone:		Work phone:	
Mobile phone:			
E-mail:			

Healthcare Identifiers

Medicare No.		Ref No:		Expiry:	
Pension/Health Care Card No.				Expiry:	
Pension card type:	Pensioner Concession Card	Health Care Card	Commonwealth Seniors Health Card		
DVA No:		Conditions:	Gold	White	Orange

Next of kin

Name:		Relationship to you:	
Address:			
Phone contact:			

Emergency Contact details

Name:		Relationship to you:	
Address:			
Phone contact:			

Health Information — this information will be scanned into your medical record ready to be discussed and entered by your doctor at your first consultation.

Your privacy is very important to us. 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. The information collected in this form will be kept confidential at all times. All staff employed at this clinic are bound by a confidentiality agreement in accordance with accreditation standards. A copy of our privacy policy is available at the front desk, on our practice information sheet and on our website.

Allergy Information

Do you have any allergies or are you sensitive to drugs or dressings?

- No
 Yes – provide details and discuss further with your doctor the severity of the allergy. _____

Current Medications

Please list (or attach) all your current medications, including complementary and over-the-counter medicines (e.g. vitamins and supplements)

Medical History

Do you have or have you had a history of the following?

- Surgery – provide details: _____
 Asthma
 Diabetes
 Hypertension
 Other – provide details: _____

History of Workers Compensation — Please note we do not take on existing Workers Compensation Claims that have been seen by a GP elsewhere. We will however offer you general medical care and accept new Workers Compensation Claims.

Have you ever had a workers compensation claim?

- No
 Yes – please provide details of your previous injury/claim. If yes, has this claim been finalised? No Yes

Social History

Occupation: _____

Retired

- No
 Yes

Lifestyle Risk Factor Information

Do you smoke?

- No
 Ceased – Ex smoker, year stopped _____
 Yes - how many cigarettes per day _____

Do you drink alcohol?

- No
 Yes - how many standard drinks per day _____ OR week _____

Recreational Drug Use

- No
 Yes - type _____ frequency _____

Do you do regular exercise?

- No
 Yes – give details _____

Family Health History Information

Unknown

- Yes (e.g. adopted)

Is your mother alive?

- Yes
 No - age at death _____ cause of death _____

Has your mother had:

- Diabetes _____
 Hypertension (high blood pressure) _____
 Heart Disease _____
 Stroke _____
 Cancer – type: _____
 Mental Illness _____
 Asthma _____
 Other significant - provide details: _____

Is your father alive?

- Yes
 No - age at death _____ cause of death _____

Has your father had:

- Diabetes _____
 Hypertension (high blood pressure) _____
 Heart Disease _____
 Stroke _____
 Cancer – type: _____
 Mental Illness _____
 Asthma _____
 Other significant - provide details: _____

Have any of your siblings had:

- Diabetes _____
 Hypertension (high blood pressure) _____
 Heart Disease _____
 Stroke _____
 Cancer – type: _____
 Mental Illness _____
 Asthma _____
 Other significant - provide details: _____

Patient Consent – this consent will be scanned into your medical record at Mudgee Medical Centre	
I consent to SMS reminders being sent for any future appointments to my mobile phone.	<input type="checkbox"/> Yes <input type="checkbox"/> No
I consent for a doctor or staff to leave a message on my voicemail/answering machine.	<input type="checkbox"/> Yes <input type="checkbox"/> No
I understand that I will be asked on every visit if a doctor uses AI to record my consultation.	<input type="checkbox"/> Yes <input type="checkbox"/> No
I consent to my doctor accessing My Health record.	<input type="checkbox"/> Yes <input type="checkbox"/> No
I consent to my doctor or practice nurse accessing the Australian Immunisation Register	<input type="checkbox"/> Yes <input type="checkbox"/> No
I consent to my doctor or practice nurse accessing the National Screening Register	<input type="checkbox"/> Yes <input type="checkbox"/> No
I consent to being sent a follow-up reminder/recall notice for treatment and preventative healthcare via SMS, phone call or post	<input type="checkbox"/> Yes <input type="checkbox"/> No
I understand that I will be asked on every visit if I consent to a medical student or trainee doctor being involved in my consultation.	<input type="checkbox"/> Yes <input type="checkbox"/> No
I understand that it is my responsibility to inform the staff at Mudgee Medical Centre if any of the details on this form change.	<input type="checkbox"/> Yes <input type="checkbox"/> No
I understand that the practice requires a minimum of 2 hours' notice for cancellation of appointments. Short notice cancellation or failure to attend my appointment may result in a non-rebatable fee and I will not be able to make another appointment until this fee is paid.	<input type="checkbox"/> Yes <input type="checkbox"/> No
I understand that if a third party (except health professionals involved in my health care) wishes to access my medical information that the practice will require my written consent and signature. I will also receive a phone call from staff to confirm that I have signed a written consent before my medical information is released.	<input type="checkbox"/> Yes <input type="checkbox"/> No
I understand that Mudgee Medical Centre is a private practice and charges a private fee if I am not on a pension or hold a Health Care Card.	<input type="checkbox"/> Yes <input type="checkbox"/> No
I understand that there may be a private fee for some procedures including for those with a pension or Health Care Card.	<input type="checkbox"/> Yes <input type="checkbox"/> No
I understand that Mudgee Medical Centre will not tolerate any abusive behaviour.	<input type="checkbox"/> Yes <input type="checkbox"/> No
I understand that Mudgee Medical Centre does not take on existing workers compensations claims that have been seen by a GP elsewhere.	<input type="checkbox"/> Yes <input type="checkbox"/> No
I understand that it is my responsibility to chase up the claim number of any new workers compensation claim and advise Mudgee Medical Centre in a timely manner otherwise I will be responsible for the payment of the account.	<input type="checkbox"/> Yes <input type="checkbox"/> No
I understand by signing this consent that I am (as a patient/parent/guardian) consenting to the collection of my personal information, and that it may be used or disclosed by the practice for the following purposes: <ul style="list-style-type: none"> • Administrative purposes in the operation of our general practice. • Billing purposes, including compliance with Medicare requirements • Follow-up reminder/recall notices for treatment and preventative healthcare. • Disclosure to others involved in my health care, including treating doctors and specialists 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. • Accreditation and quality assurance activities to improve individual and community health care and practice management. • For legal related disclosure as required by a court of law. • For the purposes of research only where de-identified information is used. • To allow medical students and staff to participate in medical training/teaching • To comply with any legislative or regulatory requirements. E.g. notifiable diseases. • For use when seeking treatment by other doctors in this practice. 	<input type="checkbox"/> Yes <input type="checkbox"/> No

Patient name: _____

If not patient signing – your name _____

Your relationship to patient (e.g. Mother, Father, Guardian) _____

Signature: _____

Date: _____

Mudgee Medical Centre and Mudgee Skin Cancer Clinic

145 Church Street,
Locked Bag 2002,
Mudgee, NSW, 2850.
Phone (02) 6372 8100 Fax (02) 6372 8199



Dr Anthony EGAN - MB BS (Hons), DRANZCOG, DCH, Dip DERM, FACRRM - Provider No. 369756Y
Dr Geoffrey BENNETT - MB BS, DipRACOG, DA (UK) - Provider No.386117K
Dr Craig HEARN - MB ChB (UCT), FRACGP - Provider No. 2518242T
Dr Peter BRYANT - MB BS, FRACGP, FACRRM, DRANZCOG (Adv) - Provider No. 241783CA
Dr Elizabeth KENNEDY - MB BS, FRACGP, FACRRM, Dip RGA - Provider No. 2728419B
Dr Yangqing (Tommy) TAN - BMed FRACGP - Provider No. 4264834F
Dr Edward LEE - MB BS (Hons), BMedSc, DRANZCOG (Adv), DCH, FACRRM - Provider No. 4653976X
Dr Preethi Pampapathi - B Sc, MD (USyd), FRACGP - Provider No. 538868BT
Dr Samantha Graham - MD, BMLSc, FRACGP - Provider No. 5970485F
Dr Keshev Sivakumar - BHSc (Hons), MD, FRACGP - Provider No. 5459255H
Dr Lauren Dunstan - B Med, MD, BSc (Hons), DCH, FRACGP - Provider No. 5100597L

Website: <https://www.mudgeemedical.com.au>
ABN 57 155 634 836

I have transferred my care to Mudgee Medical Centre and they require a full copy of my medical records held at your practice for ongoing care (please send in xml format only either on a CD or USB stick).

If I have been registered for My Medicare at your practice I wish to withdraw my Registration.

TRANSFER OF MEDICAL RECORDS TO MUDGEE MEDICAL CENTRE CONSENT FORM

Name of previous medical practice _____

Address: _____

Phone: _____ Fax No _____

Re: Patient Name: _____

Patient date of birth: _____ Patient phone number: _____

Patient authority: (*Patients 16 years and over must sign to transfer their medical records*). I hereby give permission for you to forward to Mudgee Medical Centre medical records that may be relevant to my ongoing care. I understand that I may be charged an administration fee for the release of this information to be sent to Mudgee Medical Centre. If payment is required I give permission for you to contact me on the above mentioned phone number to organise payment.

Patient's signature _____ Date _____
or Guardian's signature if patient is unable to sign

If this patient has had any type of Care Plan, Review or Health Assessment in the past 12 months please provide details here: _____

Mudgee Medical Centre would prefer the following options for receiving medical records:

1. **CD or USB Stick** – export patient's file in **xml format**. The advantage of this is that records in xml format can be imported straight into our Best Practice software in the correct fields with no paper or scanning involved.
2. **FAX** Patient Health Summary, specialist letters and results that may be relevant to the patient's ongoing care to 02 6372 8199

*****PLEASE DO NOT SEND LARGE PAPER FILES*****