New Patient Information about Wingham Family Health Clinic (WFHC)

Welcome to Wingham Family Health Clinic. We're pleased you're considering joining our practice. Please take a moment to read the following information about how our clinic operates.

Choosing your doctor
We encourage you to choose a preferred doctor for your care. Your selected doctor will also complete the initial eScript check.

Preferred doctor:
☐ Dr Callum Walker – Private Billing Provider
☐ Dr Iman Fouda – Bulk Billing Provider
☐ Dr Francy Garcia – Private Billing Provider
☐ Dr Fiorella Alvarado – Private Billing Provider

Our fees
WFHC is a **Mixed billing practice**. We bulk bill children under 16 years of age, if you are seeing a Bulk Billing Provider**,** as well as eligible Medicare health plans, government vaccinations and health assessments.

- **Initial consultation:** 30 minutes – $210 (Medicare rebate $87.10)
- **Standard consultation:** 15 minutes – $105 (Medicare rebate $45.05)

Payment is required on the day of your consultation.

Our approach to your care
We provide care based on **conventional, evidence-based medicine** and do not offer alternative therapies.
For patient safety and continuity of care, we are unable to accept new patients who are currently taking opioids (e.g. Endone or Tramal) or benzodiazepines (e.g. Valium), except where appropriate for palliative care.
Your first appointment will be booked as a 30-minute consultation to allow your doctor time to get to know you, discuss your medical history and establish your ongoing care.
Thank you for choosing Wingham Family Health Clinic. We look forward to welcoming you to our practice.

Patient acknowledgement
I acknowledge that I have read and understood the above information.

Patient name: _____
Signature: _____ **Date:** _____
If signing on behalf of patient: _____
Relationship to patient: _____

Wingham Family Health Clinic

Patient Information / Registration

The information on this form is used to provide the best quality care. Your personal health information is kept private and secure as required by federal and state privacy laws.

Title: MR / MRS / MS / MISS / MAST / OTHER _____ **Family Name:** _____

Given Name: _____ **Middle Name:** _____

Preferred Name: _____ **Date Of Birth:** _____

Birth Sex: Male / Female **Gender Identity:** _____ **Pronouns:** _____

Ethnicity: Aboriginal / Torres Strait Islander / Aboriginal And Torres Strait Islander / Australian Non-Indigenous /

Other _____ **Country Of Birth:** _____

Preferred Language: _____ **Interpreter:** YES / NO

Phone Number: Mobile _____ Home: _____ Work: _____

Residential Address: _____

Postal Address (If Different): _____

Email Address: _____

Medicare Number: _____ **Line Number:** _____ **Expiry Date:** _____

Pension / HealthCare / Commonwealth Seniors Card Number: _____ **Expiry Date:** _____

(Please Circle)

Private Health Insurance: Yes / No Provider _____ _____**Member no** _____

DVA Number: _____ **DVA Card Type:** GOLD / WHITE / ORANGE

Emergency Contact: NAME _____ PHONE NUMBER_____

RELATIONSHIP TO YOU _____

Religion: _____ **Occupation:** _____

Our practice may use reminder systems such as SMS messages to help you maintain your health, such as appointments, vaccinations, health checks and other reminders. We will need to link your mobile phone to allow this to happen.

Information collection and usage consent:

Your consent is required to collect and use information about you in the following ways:

- Administration and Billing purposes
- Provide information to other health providers involved in your healthcare
- For compliance with any legal or regulatory requirements e.g. notifiable diseases
- De-identified data for research and quality assurance activities

Electronic Consent:

** I consent to Wingham Family Health Clinic sending me/my information via UNSECURED correspondence in the form of SMS or emails for appointments reminders, test results, follow up appointments, routine health recalls, referrals, scripts & medical certificates.

Patient Signature: _____ **Date:** _____

Wingham Family Health Clinic

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Family Name: _____ **Given Name:** _____

ALLERGIES:

Do you have any ALLERGIES to Medicines or anything else: YES / NO

Reaction To What?	Kind Of Reaction (e.g. Rash)?

Current medications

IMMUNISATIONS:

Have you had all normal childhood vaccinations: YES / NO

Have you had any additional vaccinations (e.g. travel): YES / NO

SCREENING:

Last Screening / Check	Yes / No
Pap Smear / Cervical Screening	
Breast Screen / Mammogram	
Bowel Screening	

MEDICAL AND FAMILY HISTORY:

Problems	Previously (Approx Year) YOU	Active Now YOU	Your Mother	Your Father	Other First Degree Relative
Angina / Heart Disease					
High Blood Pressure					
Diabetes					
Asthma					
Epilepsy					
Stroke					
Cancer – Location					
Thyroid Deficiency / Overactivity					
Depression / Anxiety / Other					

Any other MAJOR operations or health conditions that you have been admitted to hospital / seen a specialist for:

Operation / Health Condition	Year	Reason

SMOKING / VAPING:

SMOKING: Non-Smoker ☐ Smoker ☐ Ex-Smoker ☐ Year Ceased _____ Average Per Day _____

VAPING: Non-Vaper ☐ Vaper ☐ Ex-Vaper ☐ Year Ceased _____

ALCOHOL:

Non-Drinker ☐ Current Drinker ☐ Days Per Week _____ Standard Drinks Per Day _____