Dr James Orford

MBBS FRANZCOG
Obstetrician & Gynaecologist
IVF Specialist
Laparoscopic Surgeon

NEW PATIENT INFORMATION FORM

Thank you for filling out our patient information form. Please complete to the best of your ability. If you have any questions, please ask the reception staff. We need this information to provide you with the best quality care. The information on this sheet is kept private and secure as required by Federal, State and local Government privacy laws.

Please notify us as soon as possible if there are any changes to your contact details. Accurate details not only help us identify you and your medical records, it also allows us to contact you promptly about tests, results, appointments, etc.

PATIENT DETAILS

Title	**Surname** *(as shown on Medicare card)*	**Given Name** *(as shown on Medicare card)*	**Date Of Birth**

Gender *(optional)*	
Female ☐ Male ☐ Non Binary ☐	I use a different term: *(Please state)*

Marital Status *(optional)*
Single ☐ Married ☐ Separated ☐ Defacto ☐ Divorced ☐ Widowed ☐

Occupation *(optional)*

Home Address	**Postal Address** *(if different to home address)*

Home Telephone Number	**Work Telephone Number**	**Mobile Phone Number**

Email

My preferred method of contact is: HOME PHONE ☐ WORK PHONE ☐ MOBILE PHONE ☐ EMAIL ☐

Medicare Card Number	**Patient Ref Number**	**Expiry Date**

Department Of Veterans Affairs (DVA) Card Number	**Colour**	**Expiry Date**
	Gold ☐ White ☐	

Private Health Fund	**Membership Number**

NB - Have you been with your health fund for a minimum of 12 months as there may be waiting periods for obstetric care? If not, please ensure to discuss the fees with our reception staff

Nucleus Medical Suites
Building B, Suite 25
23 Elsa Wilson Drive
Buderim Q 4556

Ph – 07 5441 5700
Fax – 07 5441 5477
E – admin@drjamesorford.com.au
www.drjamesorford.com.au

Referring Practitioner's Name
Usual General Practitioner *(if different to above)*
If you would like other Healthcare Practitioner to receive copies of our correspondence, please list their details below

Emergency Contact Name	**Relationship To You**

Home Telephone Number	**Work Telephone Number**	**Mobile Phone Number**

Do you have any special needs, eg, limited mobility, sight or hearing which we need to know about?
Yes ☐ No ☐ If yes, please state along with any requirements, eg, translator, etc.
Do You Have An Advance Health Care Directive For End Of Life Care?
Yes ☐ No ☐ If yes, please supply contact details:
Would you like a chaperone when you see Dr Orford?
Yes ☐ No ☐ If yes, we will organise for a staff member to be present.
How did you hear about Dr Orford?

CULTURAL DETAILS

Australia is a genuinely multi-cultural society. Hence, knowing your cultural / religious details can help us provide health care that meets your individual needs.

If You Identify As Aboriginal And/Or Torres Strait Islander And/Or South Sea Islander And Wish To Have This Recorded, Please Indicate Below *(optional)*:		
 Aboriginal ☐	 Torres Strait Islander ☐	 South Sea Islander ☐
If You Wish To Self-Identify Your Cultural Background Please Specify Below *(optional)*:		
Country Of Birth:		

Is English Your First Language?	**If Not, Do You Require An Interpreter?**	**Please Specify Your First Language**
Yes ☐ No ☐	Yes ☐ No ☐	
If You Wish To Self Identify Your Religion, Please Specify Below *(optional)*:		

MEDICAL INFORMATION

List Current Medications *(including prescription drugs, vitamins, etc)*	**List Dosage**
Do You Have Any Allergies? *(medications/foods/material)*	**Describe Reaction**
Immunisation Status	
Childhood	Yes ☐ No ☐ Unsure ☐
Influenza	Yes ☐ No ☐ Unsure ☐
Measles, Mumps, Rubella	Yes ☐ No ☐ Unsure ☐
Chicken Pox (Varicella)	Yes ☐ No ☐ Unsure ☐
Covid 19 (Patient)	Dose 1 ☐ Dose 2 ☐ Booster ☐
Covid 19 (Patient Partner: _____)	Dose 1 ☐ Dose 2 ☐ Booster ☐
Admin Only – Covid 19 Vaccination Certificate/s Sighted. Patient Yes ☐. Partner Yes ☐. By:	
Tobacco	
I Have Never Smoked ☐	I Ceased Smoking - / /
I Currently Smoke Per Day	
Alcohol	
I Do Not Drink Alcohol ☐	I Ceased Drinking - / /
I Drink Per Day ☐ Month ☐	
Recreation Drug Use	
I Do Not Use Recreation Drugs ☐	I Ceased Recreational Drugs - / /
I Use (Type And Frequency):	
Have You Ever Had A Pap Smear? If Yes:	
Date Of Last Pap Smear:	Was It Normal? Yes ☐ No ☐
Your Approximate Height	**Your Approximate Weight**

If You Have Had Any Previous Pregnancies, Please Complete The Following					
Date	**Live (Y/N)**	**M/A/E****	**Weeks**	**Delivery**	**Comments**

***M/A/E – Miscarriage, Abortion, Ectopic*

Have You Been Diagnosed With Any Of The Following Conditions?		
☐ Cancer	☐ Clots In The Legs Or Lungs	☐ Cystic Fibrosis
☐ Endometriosis	☐ Epilepsy	☐ Heart Disease
☐ Kidney Disease	☐ Polycystic Ovarian Disease	☐ Sexually Transmitted Infection
☐ Thalassemia	☐ Hereditary Condition	☐ Diabetes
☐ Abnormal Blood Pressure	☐ Abnormal Thyroid	☐ Other (Please Provide Details)
If You Selected Any Of The Above, Please Provide Details		

Surgical History		
Date Of Operation	**Procedure**	**Findings**

I confirm the information I have provided is, to the best of my knowledge, accurate and there is no other information I am aware of which could influence the medical treatment/advice provided to me	
Name (please print):	
Signature:	**Date:** / /

PRIVACY ACT

Your privacy is our concern. Dr James Orford and staff respect your right to privacy and acts in accordance with the National Privacy Act and the Australian Privacy Principles. All information collected in this practice is treated as sensitive information. Should you wish to read our privacy policy in full, a copy can be found on our website. If you would like a copy, please ask Dr Orford's staff and they will be happy to give you one.

As well as the information collected on this patient information sheet, we may also collect the following:

- Details of consultations you have with Dr Orford's practice
- Any additional information provided to us by your referring practitioners
- Clinical photographs, ultrasounds, pathology or radiology results, etc

We will only use the information obtained from you to:

- Assist Dr Orford and staff in providing services and care for you
- Assist the practice with any internal administrative requirements, eg, billing, debt collection
- Disclose selected information to other health services involved in supporting your health care management, eg, another Specialist, pathology, radiology, hospital, your referring practitioner, etc

We will not disclose your personal information to another person except when:

- You have provided us with written consent
- The use is for direct mailing in specific circumstances and where a person would reasonably expect such use or disclosure
- It is required by Commonwealth or State legislation or in circumstances related to public interest or public or individual health and safety

You are entitled to have access to, and request the amendment of, personal information that Dr Orford's practice has collected about you. This can ONLY be done by arranging an appointment with Dr Orford. Please speak with Dr Orford's staff so they can organise this for you. A standard consultation fee will apply, however, this cannot be claimed back from Medicare or your health fund.

Consent To Release Of Information

I give my consent to Dr James Orford's Practice, or their agents and advisors, to contact medical practitioners, health care professionals or other bodies I have consulted to obtain health and other information that may be pertinent to my care. I authorise those medical practitioners, health care professionals and/or other bodies to release such information, which may include sensitive health information, to Dr James Orford's Practice or their agents and advisors, as may be requested. I understand that unless I advise otherwise, Dr James Orford's Practice will continue to liaise with/contact medical practitioners, health care professionals or other bodies on matters related to my ongoing care.

Please tick yes or no below to indicate if you give permission/consent for Dr James Orford's Practice to:

Contact me via SMS regarding appointment details	Yes ☐	No ☐
Leave messages on my answering machine if necessary for my ongoing care, where information left will be to ask me to contact practice re appointment or results	Yes ☐	No ☐
Send me recalls and reminders via **post** if necessary to my ongoing care	Yes ☐	No ☐
Send me recalls and reminders via **email** if necessary to my ongoing care	Yes ☐	No ☐
Send me copies of invoices and bulk billing forms via email if necessary	Yes ☐	No ☐
Participate in telephone/video consultations if necessary to my ongoing care	Yes ☐	No ☐
Keep photographs of me and/or my baby as part of my clinical record	Yes ☐	No ☐
Contact my emergency contact when necessary. Name of person -	Yes ☐	No ☐
Disclose my personal information to: **Name of person -**	Yes ☐	No ☐

Patient Acknowledgement - I acknowledge I have read the above information and understand the requirements of Dr James Orford's Practice and myself in how to manage my personal information whilst attending Dr Orford's Practice.

Name:		**Signature:**		**Date:**	/ /