New Patient Form

Title: □Mr □Mrs □Ms □Miss □Mast □Other _____

First Name(s): _____ Surname: _____

Date of Birth: _____/_____/_____ Email:_____

Address: _____ Suburb: _____ Postcode: _____

Phone: (H): _____ (W): _____ (M): _____

Occupation: _____

Ethnicity: Aboriginal Torres Strait Islander

Other (Cultural background) please specify _____

□ Medicare No: __ __ __ __ __ __ __ __ __ __ Position on card (Ref) _____ Expiry: _____/_____

□ Pension Card: _____ Expiry: _____

□ Health Care Card: _____ Expiry: _____

□ DVA Card Number: _____ Expiry: _____

□ Private Health Fund: _____ Member No: _____

Preferred language: _____ Religious Affiliation: _____

Emergency Contact Details:

Name:_____ Relationship: _____ Contact Ph: _____

Next of Kin Contact Details: ***Same as Emergency Contact*** □

Name:_____ Relationship: _____ Contact Ph: _____

Special needs? (please specify): _____

Our practice uses a reminder system to improve the quality of your healthcare. We remind patients when they are due for services such as vaccinations, yearly check-ups, cervical screenings, chronic disease management, etc. Reminders may be sent to you via SMS, telephone or post.

If you **do not** wish to participate in our practice reminder systems, please tick this box □

Medical History:

Do you have any allergies to medicines or anything else? No □ Yes □

Details: _____ Reaction(s)_____

Current Medications: _____

_____

Childhood immunisations:

Up to date Not given Unsure

Patients: Height: _____ **Patients Weight:** _____

PLEASE TURN PAGE OVER …….

Your Health History: □ None (please tick relevant conditions)

	Diabetes		High Blood Pressure		Major Operations:
	Asthma		Depression/Anxiety		Other:

Family Health History: □ None

Mother (please tick relevant conditions)

	Diabetes		Mental Illness/ Depression		Heart Disease/Stroke/High Blood Pressure
	Asthma		Cancer		Other:

Father (please tick relevant conditions)

	Diabetes		Mental Illness/ Depression		Heart Disease/Stroke/High Blood Pressure
	Asthma		Cancer		Other:

Social History:

□ Smoker □ Non-smoker □ Ex-smoker

Alcohol intake: How many per day? _____ How many days per week? _____ □ Non-drinker

Health checks:

Last Skin check: _____ Last pap smear (for females):_____

How did you hear about us?

■ Family/Friend ■ Website/Google ■ Facebook □ Letterbox Flyer □ Radio □ Signs/posters

■ Newspaper ■ Baby Nurse ■ Cincotta Chemist □ Other: _____

PERSONAL & HEALTH INFORMATION CONSENT

We respect your rights to privacy and take our privacy obligations seriously. We comply with the Australian Privacy Principles, found under the Privacy Act 1988 (Cth). Our Privacy Policy can be obtained from our reception or our website.

Our practice collects information from you for the primary purposes of providing quality healthcare. We require you to provide us with your personal details and full medical history so that we may properly assess, diagnose, treat and be proactive in your healthcare needs. This means that we will use the information for administrative purposes, billing, disclosure to other individuals in your health care; including specialists and other treating doctors outside our practice and disclosure to other doctors in our practice including locums to assist in your medical care and teaching. The practice may occasionally be involved in research and quality assurance activities to improve individual and community health and practice management. We wish to assure you that at all times your health information is treated with the utmost respect and confidentiality.

I have read and understood the above information regarding my medical information and am aware I can request a full copy of the privacy and collection statement.

Patient signature:_____ Date:_____/_____/_____

Parent/Guardian signature (if applicable): _____