New Patient Information Form

To ensure your medical record is accurate and reflects your individual personal needs, we request that you complete the following information. This information remains as part of your medical file, it will assist us in gaining the best health outcomes for you by facilitating communication with specialists. Thank you for your assistance.

PERSONAL DETAILS:

Patient full Name: Mr/Mrs/Miss/Ms/Master____

Preferred Name:______________________ **Date Of Birth**______________________

Sex: Male / Female / Other____

Ethnicity: (circle) Aboriginal / Torres Strait Islander / Non Aboriginal Torres Strait Islander

Country of Birth: ______________________ **Religion:** ______________________

Street Address: ____

Suburb: ______________________ **Postcode:**______________________

Contacts: Home Phone:______________________ **Work Phone:** ______________________

Mobile Number: ______________________ **Preferred Contact:**______________________

Email Address: ____

Do you Consent to text messages and/or email correspondence? YES / NO

Medicare Number:	Ref No:	Expiry Date:
DVA Number:	Ref No:	Expiry Date:
Private Health Fund:	Ref No:	Expiry Date:
Pension Card Number:	Ref No:	Expiry Date:
Health Care Number:	Ref No:	Expiry Date:

NEXT OF KIN:

Name: ______________________ **Relationship to you:** ______________________

Home Phone Number: ______________________ **Mobile Number:** ______________________

Street Address: ____

Suburb: ______________________ **Postcode:** ______________________

EMERGENCY CONTACT:

Name: ______________________ **Relationship to you:** ______________________

Home Phone Number: ______________________ **Mobile Number:** ______________________

Street Address: ____

Suburb: ______________________ **Postcode:** ______________________

MEDICAL DETAILS:

Allergies: Do you have any allergies? (including medications, food, insects, other) or are you sensitive to any drugs or dressings?

Allergy: ______________________________

Reaction: ____________________ **Severity:** Mild / Moderate / Severe

Allergy: ______________________________

Reaction: ____________________ **Severity:** Mild / Moderate / Severe

Medications: Are you currently taking any medications?
(including over the counter medications and the pill) YES / NO

List: ______________________________

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FAMILY HISTORY:

Have your parents had any significant medical conditions?

List: ______________________________

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Mother Alive? YES / NO **Age at Death?** __________ **Cause of Death** __________

Father Alive? YES / NO **Age at Death?** __________ **Cause of Death** __________

SOCIAL HISTORY:

Marital Status: __________________ **Do you have children?** __________

Are you an Elite Athlete? YES / NO **Are you Breast Feeding?** YES / NO

Do you have an Advanced Health Care Directive? YES / NO

Do you have Enduring Power of Attorney? YES / NO

Who do you live with? ______________________________

Current Occupation: __________________ **Retired:** YES / NO

Do you Drink Alcohol? YES / NO **How many standard drinks?** ____ **per:** DAY / WEEK / MONTH

Do you smoke Tobacco? YES / NO **How many?** _____ **per:** DAY / WEEK / MONTH **Ceased Date:** _______

How did you hear about our clinic? eg: Internet, Word of Mouth ______________________________

PLEASE NOTE WE ARE A PRIVATE BILLING PRACTICE. PAYMENT OF YOUR ACCOUNT IS REQUIRED ON THE DAY.

PRIVACY: This practice is committed to maintaining the confidentiality of your personal health information at all times. This information is only available to authorised members of staff.

I have read the information above and understand the reasons why my information has been collected, I am also aware that failure to provide any information may compromise the quality of healthcare and treatment that is given to me.

Patient Signature: ______________________________ **Date:** ____________________