Alive & Kicking MEDICAL PRACTICES PTY LTD

Bundilla Clinic · Brightwater Medical Centre · Parklands Medical Centre

New Patient Details Form

Date of initial consultation: ..... / ..... / .....

Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master ☐ Dr

Last Name: ..... Given Names: .....

Date of Birth: ..... Gender: .....

The following information will assist us in the planning and provision of the best possible care:

Are you of Aboriginal or Torres Strait Islander origin?

☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Both, Aboriginal and Torres Strait Islander

What is your cultural background?

Country of Birth: ..... Is English your first language? ☐ Yes ☐ No

If English is not your first language, do you require an interpreter? ☐ Yes ☐ No

Street Address: .....

Suburb: ..... Postcode: .....

Home Phone No: ..... Work Phone No: .....

Mobile No: ..... Email: .....

How would you like us to contact you? ☐ Home Phone ☐ Work Phone ☐ Mobile ☐ Email ☐ Post

Can we SMS or leave a message on your message-bank regarding an appointment? ☐ Yes ☐ No

Can we leave a message with a family member who answers the phone regarding an appointment? ☐ Yes ☐ No

If *yes* - please state their name and relationship to you: .....

Can we put your name on a formal reminder system for preventive care? ☐ Yes ☐ No

PLEASE SIGN HERE IF YOU CONSENT TO THE ABOVE: .....

Medicare Card No: ☐☐☐☐ ☐☐☐☐☐ ☐ Ref: ☐ Expiry Date: .....

☐ Health Care Card **or** ☐ Pension Card No: ..... Expiry Date: .....

☐ Private Health Insurance Fund ..... Member Number ..... Ref: ☐

☐ DVA Card No: ..... Expiry Date: ..... ☐ Gold ☐ White

Next-of-Kin: ..... Relationship: ..... Ph No: .....

Emergency Contact: ..... Relationship: ..... Ph No: .....

How did you hear about this practice? (OK to tick more than one box)

☐ Yellow Pages ☐ Doctor ☐ Newspaper / Weekly ☐ Facebook

☐ Yellow Pages Online ☐ Employer ☐ Google Search ☐ Friends or Family

☐ Passing By ☐ Signage ☐ Other: .....

Privacy Statement:

We value your privacy. All information about you is kept in the strictest confidence and we operate in accordance with the *Privacy Act (1988)* and *Privacy Amendment (Enhancing Privacy Protection) Act 2012*. We are committed to protecting your privacy and ask for your consent for the use and disclosure of your personal health information as required during your health care.

☐ **I CONSENT TO THE USE AND DISCLOSURE OF MY PERSONAL HEALTH INFORMATION AS REQUIRED FOR MY HEALTH CARE**

Signature: ..... Date: .....

OFFICE USE ONLY: Entered ☐ Scanned ☐

Name: ..... **Date of Birth**: .....

Smoking: ☐ Non-smoker ☐ Smoker - how many/day: ..... ☐ Ex-smoker - year stopped: .....

Alcohol: ☐ Non-drinker ☐ Drinker - how many days/week: ..... How many std drinks/day: .....

Past Drinker: ☐ No ☐ Yes: ☐ Occasional ☐ Moderate ☐ Heavy

Year started (if known): ..... Year stopped (if known): .....

What is your weight: ..... **What is your height:** .....

Please list any medications that you are currently taking (including vitamins and herbal medicines):

Name of medication: ..... Strength: ..... Daily Dose: .....

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Name of medication: ..... Strength: ..... Daily Dose: .....

Have you had any immunisations recently? ☐ Flu Vaccine ☐ Pneumococcal Vaccine ☐ Other - please state:

.....

If child - are all childhood immunisations up-to-date? ☐ Yes ☐ No: .....

Do you have any significant past medical history? ☐ No ☐ Yes: .....

.....

Do you have any known allergies? ☐ No ☐ Yes: .....

.....

Have you ever had an allergic reaction? ☐ No ☐ Yes: .....

Do you have any significant family history? ☐ Don't know ☐ No ☐ Yes - please complete details below:

☐ Diabetes ☐ Type 1 ☐ Type 2 Family Member: .....

☐ Cancer Type of Cancer: ..... Family member: .....

☐ Heart Disease Family member: .....

☐ Hypertension Family member: .....

☐ Stroke Family member: .....

☐ Depression Family member: .....

☐ Other: .....

Mother - alive? ☐ Yes ☐ No Age at death: ..... Cause of death: .....

Father - alive? ☐ Yes ☐ No Age at death: ..... Cause of death: .....

What recreational activities do you participate in? .....

..... Elite athlete? ..... ☐ Yes ☐ No

Marital Status: ..... **Occupation:** .....

Accommodation: ☐ Own home ☐ Nursing home ☐ Other: .....

Live with: ☐ Alone ☐ Spouse ☐ Relative ☐ Friend

OFFICE USE ONLY: Entered ☐ Scanned ☐