NEW PATIENT FORM

We are committed to providing our patients with the best care. To do this it is essential that your personal information is correct and up to date.

PATIENT'S INFORMATION (please print) Record Number: (office use only) _________________

Title: (circle) Mr Mrs Ms Miss Dr

First Name: __________________Surname:__________________________Preferred name: ________

Date of Birth: _____/____/_____ Sex: Male ☐ Female ☐ Occupation: _________________________

Are you a former serving member of the Australian Defense Force? Yes ☐ No ☐

Marital Status: (circle) Married Divorced Widowed Single Defacto

Do you identify as being of: Aboriginal descent?: Yes ☐ No ☐ Torres Strait Islander descent? Yes ☐ No ☐

Is English your second language?: Yes ☐ No ☐

Ethnicity/ Country of Origin: ____________________________(e.g. Irish, Chinese, English)

Religion: (if applicable) _____________________Do you require an interpreter? Yes ☐ No ☐

Address: ____

Postcode: _____________________ State: _____________Phone: __________________________________

Postal Address: ____

Mobile: ___________________________ Work: ____

Email: ____

PATIENT'S NEXT OF KIN – EMERGENCY CONTACT

Name: ______________________________ Relationship to patient: ________________________________

Phone: ___________________ Mobile: ____________________ Work: _________________

WHICH IS THE BEST WAY FOR US TO CONTACT YOU FOR URGENT OR ROUTINE RECALLS?

Please tick the appropriate answer:

1. By home phone ☐ 2. By mobile phone ☐ 3. By work phone ☐
   Consent to SMS? Yes ☐ No ☐

NEW PATIENT FORM

BILLING

Medicare No: ____________________________ Line No: _______ Expiry: ________________

Do you have a DVA Gold or White Card?: Yes ☐ No ☐

DVA Gold Card #: __________________DVA White Card #: ______________________________

Pension / Health Card #: ________________________ Expiry: ____________________________

Private Health Insurance: ____

ALLERGIES

Do you have any allergies or are you sensitive to drugs or dressings?: Yes ☐ No ☐ (if yes please list below)

____

YOUR HEALTH HISTORY

Do you have or have you had a history of?

☐ Operations or fractures (please list below and year if known)

____

☐ Asthma ☐ Diabetes ☐ Hypertension ☐ Cancer

☐ Chronic Disease or major illness (list)

____

____

☐ Other

____

MEDICATIONS

Please list all medications including vitamins and herbal medicines:

____

____

____

NEW PATIENT FORM

IMMUNISATIONS

☐ Pneumococcal (pneumonia) - Date: ____________ ☐ Influenza - Date: _______________

☐ Tetanus - Date: ______________ ☐ Whooping Cough - Date: ______________________

☐ Childhood vaccination up to date (photocopy of record or blue book)

WOMEN'S HEALTH

Last Pap smear: __________________ Last mammogram: ____________ (if aged over 50)

Breast Check: ____________________________

MEN'S HEALTH

Last prostate check: _____________ (if aged over 40) An overall check up: _______________

SMOKING HISTORY

☐ I have never smoked

☐ Former smoker – Quit date: ______________ Number of years smoking: ________________

☐ Current smoker - number per day/week: __________☐ Number of years smoking: ________

ALCOHOL HISTORY

☐ I do not drink alcohol

☐ Rarely, light Days per week: _______________Standard drinks per day: ___________

☐ Moderate Days per week: _______________Standard drinks per day: ___________

☐ Heavy Days per week: _______________Standard drinks per day: ___________

SIGNIFICANT FAMILY HEALTH HISTORY (please tick)

Mother

☐ Diabetes ☐Hypertension ☐Heart disease ☐ Stroke ☐ Colon Cancer ☐ Depression

☐ Breast Cancer

Father

☐ Diabetes ☐Hypertension ☐Heart disease ☐ Stroke ☐ Colon Cancer ☐ Depression

NEW PATIENT FORM

Your privacy is our concern

In accordance with the Privacy Act, all information collected in this practice is treated as "sensitive information". To protect your privacy, this practice operates in accordance with this Act. We use this information you provide to manage your health care.

Selected information may be disclosed to various other health services involved in supporting your health care management. (e.g. pathology, specialists, immunisation registers)

If you have any questions or concerns how we handle your personal health information or need to arrange access to your records, please ask the staff or you doctor, as appropriate.

Reminder systems

The Cottage Surgery provides our patients with preventative care and early case detection reminders e.g. immunisation, annual health checks, pap smears.

Please let us know if you do not wish to have relevant health reminders sent to you.

Patients signature or Parent/Guardian (if child is a minor)
____

Date: _____________ Name: ______________________