NEW PATIENT FORM

Title: ☐ **Mr** ☐ **Master** ☐ **Mrs** ☐ **Miss** ☐ **Ms** ☐ **Other**

Surname: **First name(s):** **Preferred Name:**

Date of Birth:

What was your sex recorded at birth? Male Female Another Term:_______________ Prefer not to say

How do you describe your gender? Male Female Non-Binary Another Term: ___________ Prefer not to say

What are your pronouns? He/Him/His She/Her/Hers They/Them/Theirs I use a different pronoun: _______________

Residential Address: **Suburb:**

Phone Number **Mobile:** **Home:** **Work:**

Email Address:

Do you consent to receiving SMS and email reminders/correspondences? ☐ **Yes** ☐ **No**

Country of birth: **Primary Language:** **Interpreter required?** **Yes** ☐ **No** ☐

Do you identify as: ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither

Medicare Card Number: _ _ _ _ _ _ _ _ _ _ _ **Ref:** _ **Expiry:** _ _ / _ _ _ _

Concession Card: ☐ Health Care Card ☐ Pension ☐ DVA - Gold / White (circle) **Card no:** **Expiry:**

Occupation:

Next of Kin **Name:** **Phone Number:** **Relationship:**

Emergency Contact **Name:** **Phone Number:** **Relationship:**

Your health and family history- do you have or have had a history of?

Your History: ☐ Operations ☐ Asthma ☐ Diabetes ☐ Hypertension ☐ Chronic Illness ☐ Other

Please give details:

Your Family History: ☐ Operations ☐ Asthma ☐ Diabetes ☐ Hypertension ☐ Chronic Illness ☐ Other

Please Give details:

Mother Alive - Yes ☐ **No** ☐

Father Alive - Yes ☐ **No** ☐

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

________________________ _______________________________ _________________________

Current Medications (Including over the counter medications, vitamins, and minerals):

___________________________ ________________________________ ___________________________________

___________________________ ________________________________ ___________________________________

Social History: *(please tick)*

Tobacco Use: ☐ **Non-Smoker** ☐ **Ex-smoker-** Year Quit? _______ ☐ **Smoker**- How many per day? ____________

Alcohol: ☐ **Non-Drinker** ☐ **Drink-** How many days a week? _________ ☐ How many drinks per day? ___________

Please provide details of your - **Height:** __________ **Weight:** _____________

Date of last: Cervical screening:__________ **Result :** ☐ **Negative** ☐ **Other** ____________________________

Prostate Check: ____________ **Influenza immunisation:**______________

How did you hear about us? ☐ Health Engine ☐ Facebook ☐ Google ☐ Flyers ☐ Word of mouth ☐ Other _______________

THIS FORM IS DOUBLE SIDED

PLEASE TURN OVER

PERSONAL CONSENT

We require your consent to collect personal information about you. Please read this information carefully, and sign where indicated below. Elanora Heights Medical Practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. This means we will use the information you provide in the following ways:

- *Administrative purposes in running our medical practice;*
- *Billing purposes, including compliance with Medicare Australia requirements;*
- *Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals;*
- *To contact you or your family for the purposes of Recalls & Reminders.*

I have read the information above and understand the reasons why my information is collected. I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to me. I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances. I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained. I consent to the handling of my information by this practice for the purposes set out above.

<table>
<tr><td colspan="3">I have read & understand all information provided above regarding privacy & freedom of information.

I am aware that at the conclusion of all consultations there will be a request for full payment of the account.</td></tr>
<tr><td>NAME:</td><td>SIGNATURE:</td><td>DATE:</td></tr>
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