Warana Medical Centre – New Patient Form

Personal Details

Title: Mr		
Surname:		Given Name (s):
Preferred Name:	Date of Birth:	Occupation:
Gender Identity Female		Gender: Female
Preference: he/him/his		Marital Status:

Cultural

Knowing your cultural background can help us provide health care that meets your individual needs.

Are you of Aboriginal or Torres Strait Islander origin?

No

Yes, Aboriginal Yes, Torres Strait Islander Yes, Aboriginal & Torres Strait Islander

Other Cultural Backgrounds (Asian, African, Mediterranean etc)	Country of Birth:

Contact Details

Residential Address:	Suburb:
Post Code:	Mobile Number:
Home Phone:	Email Address:

Our practice uses a reminder system to help maintain your health. The practice sends reminders by post, email, telephone or SMS for appointments and procedures like vaccinations, cervical screening and other health reviews. I consent to being contacted with reminders to help me maintain my health.

Signature: Yes No Appointments Only

Health Cover

Medicare Number:	Ref:	Expiry:
Pensioner/ Health Care Card Number:		Expiry:
Pension Card Type:		
DVA Number:	Gold White	Expiry:

Do you consent to your medical records being uploaded to your 'My Health Record'? Yes No

Next OF Kin

Name:	Relationship:
Contact Number:	
Emergency Contact Name:	Relationship:
Contact Number	

Consent

We value your privacy. All information about you, at Warana Medical Centre, is kept in the strictest confidence and we operate in accordance with the Privacy Act *(1988)*. We are committed to protecting your privacy and ask for your consent for the use and disclosure of your personal health information during your health care. I consent to the disclosure/use of my personal health information by Warana Medical Centre to other health providers directly involved in my personal health care or medical treatment and that my health records may be used and de identified for shared patient data.

Do you consent to us contacting your Next of Kin in the event of an emergency or if you are unable to be reached?

If you no longer require your appointment, we would appreciate you calling to cancel so the time may be made available to other patients. **Failure to do so, prior to your appointment will result in your next visit to our centre being privately billed.**

I understand and consent to the above. YES NO

Signature	Date:
Print Name:	

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Name_____ **Date of Birth:**_____

Personal Medical History	Diabetes		
	Asthma		
	Operations		
	Hypertension		
	Chronic Illness		
	Other		

Do you have any allergies or are you sensitive to drugs or dressings? (Please list) Yes No

Allergies		

			Year	Current Medications:
Immunisations	Tetanus Booster			
	Hepatitis A			
	Hepatitis B			
	Influenza			
	Pneumococcal			Blood Pressure (Admin Use):
	Polio			
	Childhood Immunisations			

			Family Member	Extra Details (If any)
Family History	Diabetes			
	Asthma			
	Heart Disease			
	Mental Illness			
	Cancer			

Other Health Issues	Height:	Weight:
	Tobacco: Day Weekly Monthly	Smoking Ceased (date):
	Standard Alcohol Intake: Day Weekly Monthly	Drug Use: Yes No
	Sun protection: Always Often Sometimes Rarely Never	
	Females, when was your last - Pap Smear: Date: Never I Don't Know	
	Males, when was your last - Overall Check Up: Date: Never I Don't Know	
	Advanced Health Directive ☐ Enduring Power of Attorney	
	For those over 65, when was the last time you were immunised against – Influenza: Date: Never I Don't Know Pneumococcal pneumonia: Date: Never I Don't Know	