# NEW PATIENT DETAILS FORM

Date: _____

## PATIENT INFORMATION

Family Name: _____ Given Name: _____

Date of Birth: _____ Birth Sex: ◯ Male ◯ Female ◯ Unknown Preferred Name: _____

Gender Identity: ◯ Female ◯ Male ◯ Non Binary ◯ Gender Diverse ◯ Transgender ◯ Other

Pronouns: ◯ She/Her/Hers ◯ He/Him/His ◯ They/Them/Theirs

Address: _____ Post Code: _____

City: _____ Country Of Birth: _____

Ethincity: ◯ Australian Non Indigenous ◯ Aboriginal but not Torres Strait Islander

◯ Torres Strait Islander but not aboriginal ◯ Other

Phone Number: _____ Email: _____

Next Of Kin: _____ Phone: _____

Relationship: _____

Emergency Contact: _____ Phone: _____

Relationship: _____

Preferred Language: _____ Interpreter required: Yes or No? _____

**MEDICARE NUMBER:** _____ **REFERENCE NO.** _____

**EXPIRY DATE:** _____

DVA NUMBER (IF APPLICABLE): _____ EXPIRY DATE: _____

PENSION/HCC NO (IF APPLICABLE): _____ EXPIRY DATE: _____

I consent to receiving appointment reminders via SMS: YES ◯ NO ◯

I consent to receiving clinical communication (Results & Clinical Messages): YES ◯ NO ◯

I consent to receiving clinical reminders via SMS YES ◯ NO ◯

I consent to receiving information about health awareness via SMS: YES ◯ NO ◯

# NEW PATIENT DETAILS FORM

***PERSONAL & HEALTH INFORMATION CONSENT:***

Your doctor respects your rights to privacy and we take our privacy obligations seriously.
Your doctor complies with the Australian Privacy Principles, found under the privacy Act 1988 (Cth). The Privacy policy can be obtained from the website.

Your doctor requires your consent to collect personal information and health information about you. Please read this information carefully and sign where indicated below.

- Your doctor collects information from you for the primary purpose of providing you with healthcare services. We require you to provide us with your personal and health information such as your medical history so that we may provide our services to you. We also use the information you provide in the following ways:
- Appropriately manage the practice, such as conducting audits and undertaking accreditation processes, manage billings and training staff.
- Effectively communicate with third parties, including Medicare Australia, private health insurers, government departments and other practitioners involved in your healthcare.

*I have read the information above and understand why my information is collected and how it is used. I acknowledge that I am not obliged to provide any information requested of me, but that failure to do so may compromise the quality of care provided to me.*

**Patient/Guardian Signature** _____ **Date** _____

# CLINICAL QUESTIONNAIRE

Name: _____

Date Of Birth: _____

Allergies: _____

Nature of reaction: _____

Severity: ◯ Mild ◯ Moderate ◯ Severe

**Past History:** Please tick those that apply

- ◯ Heart Problems
- ◯ Stroke
- ◯ Eye Problems
- ◯ Osteoporosis
- ◯ Cancer
- ◯ High Cholesterol
- ◯ Epilepsy
- ◯ High Blood Pressure
- ◯ Blood Clots/ Bruising Issues
- ◯ Bronchitis
- ◯ Asthma
- ◯ Glaucoma
- ◯ Migraines
- ◯ Thyroid Problems
- ◯ Diabetes
- ◯ Liver Disease
- ◯ Back Pain
- ◯ Kidney Disease
- ◯ Skin Conditions
- ◯ Fractures
- ◯ Any Other: _____
- ◯ Hep B
- ◯ Hep C
- ◯ HIV
- ◯ Hearing Loss
- ◯ Arthritis
- ◯ Anxiety/Depression

**Alcohol Status** - Current Alcohol intake

◯ Non Drinker

Days Per Week: _____

Drinks Per Day: _____

**Smoking Status** - Please indicate below.

◯ Smoker

◯ Non Smoker

◯ Ex Smoker

Quantity Per Day _____

Past Smoking History - Ex Smoker

Year Started _____

Year Stopped _____

**Medications:**

Your doctor will ask you what medications you take so that they can be added to your medical file.

**Family History**

Is your mother still living? _____

If you answered no above - what was her age of death: _____

Cause of death: _____

Is your father still living? _____

If you answered no above - what was his age of death: _____

Cause of death: _____

Is there any significant family history for your mother? Please outline below

_____

Is there any significant family history for your father? Please outline below

_____

Is there any other significant family history?

_____

Relationship: _____

**Patient/Guardian Signature** _____ **Date** _____