PLAZA MEDICAL CENTRE – NEW PATIENT INFORMATION FORM

We would like you to be aware before your consultation that we will not prescribe narcotic medication - these are drugs of addiction and subject to State prescribing laws.

Mr. Mrs. Miss Ms Master Dr Religious Title Other **PLEASE PRINT CLEARLY**

First Name: _____ **Middle Name:** _____ **Preferred Name:** _____

Surname: _____ **Date of Birth:** ___/___/____ **Sex:** Male / Female / Transgender

Medicare Card Number: _____ **Reference Number:** _____ **Expiry Date:** ____/____

HCC / DVA / Pension Number: _____ **Type of Pension:** _____ **Expiry Date:** ____/____/____

These Cards MUST be Presented to Reception

Address: _____ Suburb: _____ Post Code: _____

PO Box: _____ Suburb: _____ Post Code: _____

Home Phone: _____ Work: _____ Mobile: _____

Email: _____

Preferred method of Contact: Home Phone / Work Phone / Mobile / Email / Post / Text Message

Marital Status: Single / Married / Widowed / Divorced / De-Facto / Separated

Occupation: _____ **Country of Birth:** _____ **Year Arrived in Australia:** _____

Preferred Language Spoken: _____ **Health Insurance:** Extras / Hospital / Both **Fund:** _____

How did you find us: [ ] Website [ ] Yellow/White Pages Online [ ] Yellow/White Pages Directory [ ] Google [ ] Facebook [ ] Referred [ ] Newspaper [ ] Other _____

Next Of Kin: _____ Ph: _____ Relationship to you: _____

Emergency Contact: _____ Ph: _____ Relationship to you: _____

Authorised Contact: _____ Ph: _____ Relationship to you: _____

Patient Consent Form

From 21 December 2001 the Privacy Act requires private medical practices to obtain your consent to collect personal information about you. Please read this information carefully and sign where indicated below. The medical practice collects information from you for the primary purpose of providing necessary health care. We require you to provide us with your personal details and full medical details so that we may assess, diagnose, treat and be proactive in your health care needs properly and we will use the information you provide us in the following ways: Recall & reminder system, if you do not wish to be included please let the staff know.

Consent to receive text messages from the clinic: [ ] YES [ ] NO

Administrative purposes in running our medical practice; billing purposes, including compliance with Medicare & health Insurance Commission requirements; Disclosure to other doctors in the practice including locums for your ongoing care if your usual doctor is not available; Disclosure to others involved in your health care, including treating doctor and specialists outside this medical centre. This may occur through referral to other doctors or medical tests and in the response or results returned to us following referrals. **I assign my right to benefits to the practitioner who rendered this service.**

Disclosure for statistical research and quality assurance activities to improve individual and community health care and practice management. Please be advised that your personal details such as your name address and date of birth are withheld in these situations. Therefore your identity is protected. You may elect for your information to be excluded in such activities. Please place a line through this clause if you prefer your information to be excluded.

I have read the information above and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling patient's information. I understand that I am not obliged to provide any information requested of me but that failure to do so might compromise the quality of 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 be withheld. I understand I will be given an explanation in these circumstances. I have been advised of the estimated costs in respect of the proposed medical services**. I accept responsibility for payment of this account, including if any nominated insurer does not pay the anticipated costs or declines liability of any injury claims.**

SIGNED (patient, parent or guardian): _____ **DATE:** _____

PLEASE PRINT NAME: _____

PLAZA MEDICAL CENTRE – NEW PATIENT CLINICAL INFORMATION

NAME: _____ **Date of Birth:** / /

ALLERGIES: Do you have any known allergies to medications, food or insect bites? □Yes / □No
If Yes - Allergic to: _____

MEDICAL HISTORY:
Have you or a family member ever suffered from any of the following – currently or in the past?
Please tick or write relative's title eg Mother/Father/Sibling/Grandparent

Disease	You	Family Member	Disease	You	Family Member
Heart Condition			Stroke		
High Blood Pressure			Fractures		
High Cholesterol			Bowel Cancer/Polyps		
Asthma			Breast Cancer		
Diabetes			Cervical/Ovarian Cancer		
Epilepsy			Prostate Cancer		
Thyroid Disease			Any other Cancer		
Osteoporosis			Other		
Arthritis					
Depression/Anxiety					
Mental Health					

If you answered yes to any of the above please give details and which year diagnosed:
_____
_____
_____

OPERATIONS: Have you had any operations? Please name them and the year performed.
_____
_____
_____

CURRENT MEDICATIONS: please list, including over the counter medications, vitamins etc
_____
_____
_____
_____

HEIGHT: _____ **WEIGHT:** _____

SMOKING:
□ Have you ever smoked? □Yes/ □No
□ Ex-Smoker - What year did you quit? _____
□ Smoker - how many per day? _____ What year did you commence? _____
Are you planning to quit? □Yes/ □No

ALCOHOL:
How often do you have a drink containing alcohol?
□ Never □ Monthly or Less □ 2-4 times a month
□ 2-3 times a week □ 4 or more times a week Month

How many standard drinks containing alcohol do you have on a typical day?
□ 1 or 2 □ 3 or 4 □ 5 or 6

 PLEASE TURN OVER

□ 7 to 9 □ 10 or more

How often do you have do you have six or more drinks on one occasion?
□ Never □ Less than monthly □Monthly
□ Weekly □ Daily or almost daily

Are you concerned about your drinking? □ Yes □ No

SEXUALITY: _____

CHILDREN:

Do you have children? □Yes/□No How many? _____ How many still living at home?_____

IMMUNISATIONS:
Please list what immunisations you have had and when you had them

Immunisation	Date	Immunisation	Date
Tetanus		Pertussis (Whooping Cough)	
Hepatitis A		Polio	
Hepatitis B		Yellow Fever	
Influenza (Flu)		Typhoid	
Pneumococcal (Pneumonia)		Other	

If completing this form for a child, are their immunisations up to date?

□Yes / □No

Have you ever travelled overseas in the last 12 months □Yes/ □No

If so where and when _____

FEMALE PATIENTS:
What month & year was your last Pap Smear? _____/_____ Was it Normal □Yes/ □No

Have you ever had a Mammogram or Breast Check? □Yes/ □No When _____/_____

MALE PATIENTS:
Have you had a prostate check-up? □Yes / □No When_____/_____

I consent to receive recalls and health reminders: [ ] YES [ ] NO

Signed:_____

Date: / /

Thank you for taking the time to complete this questionnaire