Forrest Road
MEDICAL CENTRE

NEW PATIENT DETAILS

This information is private and confidential and is for use in your clinical file only.
Please print and give as much detail as possible to assist us to provide quality care.

Title: Mr Mast Mrs Ms Miss Other

Surname: _____ **First Name:** _____ **Middle Name:** _____

Date of Birth: _____ /_____ /_____ **Birth Sex:** Male Female **How Do You Identify:** Male Female Other:_____

Pronouns: He/Him She/Her Them/They **Ethnicity:** Australian Aboriginal TSI ATSI Other: _____

Country of Birth:_____ **Preferred Language:**_____

Address: _____ **Suburb:** _____ **Postcode:** _____

Is your Postal Address different? _____

Home Phone No: _____ **Mobile:** _____

Email Address: _____

Medicare Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ **Reference Number**: ____ (next to name) **Expiry:**_____

Department Veteran Affairs: ___ ___ ___ ___ ___ ___ ___ **Gold / White / Orange** **Expiry:**_____

Pension Card / Healthcare Card / Commonwealth Seniors Card No: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ Ex**piry:**_____

Next of Kin: _____ **Relationship:** _____ **Phone:** _____

Emergency Contact: _____ **Relationship:** _____ **Phone:** _____

Occupation: _____ **Preferred Method of Contact** (please circle): Mobile Email Home Phone

Consent to SMS (please circle): Yes No
Consent to Emails – *These are NOT encrypted (please circle): Yes No

COMMUNICATION
Australia is a genuinely multicultural society and appreciates people of different nationalities and cultures. However, to provide appropriate care we need to communicate clearly with you.

If English is not your first language: Are you confident to consult in English? Y / N

If not, would you like us to arrange an interpreter for your consults? Y / N Preferred Language: _____

CONSENT
At Forrest Road Medical Centre, we strive to provide high quality care, appropriate to meet our client's health care requirements. By becoming a patient of Forrest Road Medical Centre and signing this new patient form I agree and consent to the following:

I consent to the use of my personal health information by Forrest Road Medical Centre and other health care providers involved in my medical treatment and health care within this centre.
I consent to the disclosure of my personal health information by the above-named practice to other health care providers involved directly or indirectly involved in my personal health care or medical treatment.

As part of preventative health services offered by this practice, we send out follow up reminders and recalls when routine investigations are due. I consent to receive follow up reminders and recalls to be sent to the above address.

**** Please note we are a Mixed Billing Practice and only Bulk Bill Pensioners and children under 16 years Monday-Friday 8am-5pm. All appointments outside of these times will incur a fee. Concession & Health Care Card Holders may be offered a discounted rate. Please check with reception for any further information on fees and rebates**.

Name: _____ Signature: _____ Date: _____ /_____ /_____

PTO

CURRENT MEDICATION AND DOSAGE:

_____

_____

ALLERGY INFORMATION: Do you have any allergies or are you sensitive to drugs or dressings?

☐ No ☐ Yes – provide details: _____

MEDICAL HISTORY: Do you have or have you had a history of the following?

☐ Surgery – provide details:
☐ Asthma
☐ Diabetes
☐ Hypertension
☐ Chronic Illness
☐ Other – provide details: _____

_____

SOCIAL HISTORY: Please circle the most appropriate answer and fill out all other areas

Marital Status: Single Married De-Facto Divorced Widowed Separated

Alcohol Consumption: Do you drink alcohol? Yes No **If yes how much:** _____

Smoking: Do you smoke? Yes No **If yes how many per day:** _____

FAMILY HISTORY: Please circle the most appropriate answer and fill out all other areas

Family History: No Significant Family History Other – see list below

MOTHER'S SIDE Diabetes Kidney Disease Asthma High Blood Pressure Heart Problems Breast Cancer Colon Cancer Stroke Depression Epilepsy Other Cancer

FATHER'S SIDE Diabetes Kidney Disease Asthma High Blood Pressure Heart Problems Colon Cancer Stroke Depression Epilepsy Other Cancer

HOW DID YOU FIND OUT ABOUT US?

Word of Mouth Relatives Drive / Walk past Leaflets / Flyers Pharmacy Internet

Other: _____

Thank you for choosing our practice.
Please help yourself to one of our brochures or speak to our friendly receptionist staff for more information on how we can assist you