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Heatley Medical & Skin Care Centre

# NEW PATIENT INFORMATION SHEET

***Please return this form to RECEPTION along with your Medicare Card and any Concession Cards***

Title: _____ First Name: _____ Surname: _____

Preferred name: _____ Date of Birth / /

Birth Sex: _____ Gender Identity: _____ Occupation: _____

Address: _____

Suburb: _____ Postcode: _____

Mobile: _____ Email: _____

**Medicare Number** Ref. No Expiry Date

__ __ __ __ __ __ __ __ __ __ __ __ __/__ __

**DVA** __ __ __ __ __ __ __ __ Gold ☐ White ☐

**Concession Card** Expiry Date

__ __ __ __ __ __ __ __ __ __ __/__ __/__ __ Pension ☐ Health Care Card ☐ Seniors Card ☐

Do you identify as Aboriginal? Yes/No

Do you identify as Torres Strait Islander? Yes/ No

Have you registered for the Closing the Gap Programme? Yes/No

Ethnicity:

Country of Birth:

Do you require an interpreter service? Yes/No

Next of Kin:_____ Phone No: _____ Relationship: _____

Emergency Contact: _____ Phone No: _____ Relationship: _____

| Allergies: Yes/No/Unknown | If yes please list type of reaction, ie nausea, rash | Please circle |
|---|---|---|
| _____ | _____ | Mild/ Moderate/ Severe |
| _____ | _____ | Mild/ Moderate/ Severe |
| _____ | _____ | Mild/ Moderate/ Severe |

**Marital Status:** Single/ Married/ De-Facto/ Separated/ Divorced/ Widowed Please circle.

Smoker: ☐ Per Day: ____ Non-Smoker: ☐ Ex Smoker: ☐ Approx Quit Date:_____ Vape: ☐

How often do you drink? Never : ☐ Once a year : ☐ Once a week: ☐ Everyday: ☐

2-3 x per week ☐ 4 x or more per week ☐

Standard drinks per occasion? 1-2 ☐ 3-4 ☐ 5-6 ☐ 6-8 ☐ 10+ ☐

**Weight:** **Height:**

Please List any Current Medications you are taking including over the counter and vitamins.

_____ _____ _____

_____ _____ _____

**Personal Medical History**: Asthma ☐ COPD ☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐

Cancer ☐ Type: _____ Stroke ☐

Mental Health ☐ _____ Anxiety ☐ Depression ☐

Other: _____

**Family Medical History**: ☐ Nil significant family medical history

Mother alive? Yes/No Cause of death: _____ Age: _____

Father alive? Yes/ No Cause of death: _____ Age: _____

| | *Family Relationship* | |
|---|---|---|
| Asthma | _____ | Other: _____ |
| COPD | _____ | _____ |
| Diabetes | _____ | _____ |
| Hypertension | _____ | _____ |
| Mental Health | _____ | |
| Depression/ Anxiety | _____ | |

Cancer *Type* _____ *Family Relationship* _____

Cancer *Type* _____ *Family Relationship* _____

**CONSENT: -**

I give consent for the following: - **(Please amend if you <u>DO NOT</u> give consent)**

✓ To be placed on any government recall register i.e. Pap register, Immunisation register, Breast screen etc.

✓ Contact via Email, Mail or Phone. This practice uses secured SMS to notify our patients with health messages, reminders, review appointments required and vaccinations. If you do not have a mobile device, we will contact you via the numbers you provide.

*In compliance with the Privacy Act, we require your consent for the treating Doctors to use the information provided on this form. This and additional information may be provided to other Doctors and/or Specialists when requesting medical imaging, pathology etc., or when referring you on. Patient information will not be released to family members without the patient's written consent. Doctors and staff will not discuss test results over the phone. It is your responsibility to arrange a follow up appointment to discuss your results. Occasionally your consult may include the presence of a medical student or GP Registrar as our doctors are actively engaged in teaching training doctors. All persons accessing your personal health information are bound by confidentiality. Please DO NOT hesitate to discuss any concerns, questions or complaints about any issues related to the privacy of your personal information with your doctor.*

Signature of Patient or Guardian: _____ Date: ____/____/_____

How did you find out about our surgery?

Word of mouth/ Relatives ☐ Advertisements ☐ Facebook ☐

Website ☐ Hot Doc / Health Search ☐ Google ☐

Other (please specify) _____

*Office use : Date / / Medicare sighted Staff Member:*