new patient form

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PERSONAL DETAILS

Today's Date: ______________________

Mr ☐ **Miss** ☐ **Ms** ☐ **Mrs** ☐ **Dr** ☐

Surname: __________________________ **Given Name:** ______________________

Gender: Male ☐ Female ☐

Date of Birth: ________/_____________/_____________

Home Address:

(Street Number) ______________ (Street Name) ____________________________________

(Suburb) ____________________ (State) ______________ (Postcode) _________________

Contact Number: (Home) __________________ **(Mobile)**___________________________

Email Address: ____

Occupation: _______________________

EMERGENCY CONTACT DETAILS

Name: _____________________________ Relationship: ______________________________

Contact Number: ____________________

CULTURAL BACKGROUND

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

Are you of Aboriginal or Torres Strait Islander background? Yes ☐ No ☐

Is English your first language? Yes ☐ No ☐

If No, do you require an interpreter? Yes ☐ No ☐

If you require an interpreter, please specify language: ___________________________

HEALTH CARE CARDS

MEDICARE

Card Number: ______________________ Reference Number (next to your name): ______

Expiry Date: ________________________

PRIVATE HEALTH INSURANCE

Health Fund: _______________________ Membership Number: ______________________

Level of Cover: _____________________

PENSION CARD HOLDER

Card Number: ______________________ Expiry Date: ______________________________

HEALTH CARE CARD HOLDER

Card Number: ______________________ Expiry Date: ______________________________

DVA CARD HOLDER

DVA Number: _______________________ Card Colour: ______________________________

HOW DID YOU HEAR ABOUT US

Mail out ☐
Google / Web ☐
Advertisement ☐
Barry Plant Real Estate ☐
Melb Uni Lightning Netball ☐
Jetts Fitness ☐
Pascoe Vale Dental ☐
Word of Mouth ☐
Facebook ☐
Current Patient ☐
Coburg Districts Football Club ☐
Hocking Stuart Real Estate ☐
Pascoe Vale Early Learning ☐

Other: _____________________________

MEDICAL HISTORY

Do you, or have you had, any of the following:	Yes	No	Details where relevant
Heart disease			
High blood pressure			
Stroke or brain haemorrhage			
Blood clots in legs or lungs			
High cholesterol			
Diabetes or raised blood sugar levels			
Kidney, urinary, or bladder disorders			
Stomach or bowel problems			
Liver disorders including hepatitis			
Any cancer or tumour, including skin cancers			
Eczema, Psoriasis, Dermatitis, other skin disorders			
Asthma, bronchitis or respiratory disorder			
Migraines			
Back or spinal problems or joint conditions			
Depression, anxiety, stress			
Any allergies?			
Any allergies to any medications?			

WOMEN ONLY – please complete this section

Do you, or have you had, any of the following:	Yes	No	Details where relevant
Complications with pregnancy or childbirth			
Problems related to menstruation or menopause			
Abnormal Pap test or mammogram			

When was your last Pap Test? ________________________________

When was your last Mammogram? ______________________________

IF THE PATIENT IS A CHILD ONLY – please complete this section

Does your child have, or have they had, any of the following:	Yes	No	Details where relevant
Asthma or other respiratory condition			
Cerebral palsy			
Depression, anxiety, stress			
Developmental or behavioural disorders, e.g Speech disorder, ADHA, Aspergers			
Diabetes			
Eczema, Dermatitis, other disorders			
Epilepsy			
Intellectual Disability			
Physical disability			
Was there any problem during the pregnancy or delivery of this child?			
Do you have any concerns about your child’s health or development?			
Are your child’s immunisation up to date?			

LIFESTYLE RISK FACTORS (ADULTS ONLY)

SMOKING STATUS

Never Smoked ☐

Ex-Smoker ☐ - When did you start smoking? ____________ When did you stop? __________

Current Smoker ☐ - How many per day? ____________________

NUTRITION

Would you say you eat healthy?

Yes, all the time ☐

Yes, most of the time ☐

Yes, some of the time ☐

No ☐

ALCOHOL CONSUMPTION

Do you consume alcohol? Yes ☐ No ☐

If Yes, how often?
Once a week ☐
2 - 3 times a week ☐
3 - 4 times a week ☐
4 - 5 times a week ☐
5 – 6 times a week ☐
Everyday ☐

PHYSICAL ACTIVITY

Do you participate in regular exercise? Yes ☐ No ☐

If Yes…

1. What type? _________________________

2. How often?
   Once a week ☐
   2 - 3 times a week ☐
   3 - 4 times a week ☐
   4 - 5 times a week ☐
   5 – 6 times a week ☐
   Everyday ☐

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MENTAL HEALTH

During the past 30 days, about how often did you feel…

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
Nervous	☐	☐	☐	☐	☐
Hopeless	☐	☐	☐	☐	☐
Restless or fidgety	☐	☐	☐	☐	☐
So depressed that nothing could cheer you up	☐	☐	☐	☐	☐
That everything was an effort	☐	☐	☐	☐	☐
Worthless	☐	☐	☐	☐	☐

CONSENT AND PRIVACY

Your medical record is a confidential document. It is the policy of this practice to maintain security of personal health information at all times in accordance with privacy laws, and to ensure that this information is only available to authorised people. More information about how the practice handles your record is available to you upon request.

Our practice undertakes research, professional development and quality assurance improvement activities to improve patient care. We use a reminder system to improve the quality of your health care, and send out reminders for procedures such as vaccinations, Pap tests and other health reviews.

We communicate regularly with our patients via mail, SMS & email. If you choose not to receive such communication please advise the Practice.

The doctors at our practice have been appointed as clinical teachers by the University of Melbourne. Please advise your doctor if you have concerns about having a student involved in your consultation, or do not wish to receive reminders in the post.

TRANSFER OF HEALTH INFORMATION

You may have a health record at another practice. If you wish to have a copy or summary of your health records transferred to this practice, please ask reception.

I acknowledge that the information provided on this registration form is true and accurate.

Signature of patient (or parent/guardian): ______________________________ Date: ___________________

Print Name: ____