New Patient Form

Date: _______________

Please circle…… Mr Mrs Ms Miss other _________

Family Name ______________________________________ First Name _______________________________

Preferred Name _______________________ Date of Birth ____________________________

Do you self-identify with any cultural background?

□ No □ Yes □ Aboriginal □ Torres Strait Islander □ Other ________________

Country of Birth? ____________________________________

Address: ____Suburb: ___________________________

Postcode: _____________ Home Phone: _____________________ Work: ____________________________

Mobile: _________________________ Email address: ____

Medicare Card number: _________________________________Your ref. on card ___________ Expiry Date:___________

Pension Card No. ____ Expiry Date:_____________________________

Healthcare Card No. (Concession Card) ____ Expiry date:______________

DVA Card no. ______________________ Gold / White (please circle) Conditions: ________________________________

Next of Kin Name: ____________________________Phone: ____________________Relationship to you: ______________

Emergency Contact Name: ______________________Phone: ___________________ Relationship to you:______________

Cancellations: If you are unable to attend your appointment we ask that you contact the surgery as soon as possible so that we may offer your appointment to another patient. Non-attendance and failure to advise the surgery may result in a $30 fee.

Information and Consent

We do not prescribe S8's (drugs of dependence) to new patients at first consultation. Our Practice Policy requires past medical history to be obtained prior to prescribing these medications at any subsequent consultations.

We value your privacy. All information about you at Tweed Coast Medical is kept in the strictest confidence and we operate in accordance with the Privacy Act (1988). Please refer to our privacy pamphlet for information.

In our practice, we have a recall and reminder system for our patients. We contact our patients either by phone, letter or sms for reminders and test result recalls and for ongoing patient care.

Please mark the boxes below if you consent to receiving sms appointment reminders and/or sms clinical reminders / communication. We may also send out occasional Health Awareness emails and Practice Information which you can opt out of at any time.

☐ Consent for sms appointment reminders ☐ Consent for sms Clinical Communication (Results and Clinical Messages)

☐ Consent for sms Clinical Reminders ☐ Consent for Health Awareness / Practice Information emails

I also consent to the use of and the disclosure of my personal health information to any health care provider involved in my medical treatment and health care.

Signed: ____

If signing on behalf of the registering patient, please state your name and relationship to the patient:

Name ______________________________ **Relationship to Patient** ___________________________

Patient Medical History Form

Tweed Coast Medical takes their role as your primary healthcare provider very seriously. The more information we have about you, the more effective the management of your health will be. We aim to identify common health problems as early as possible so as to minimize their effects, and avoid ill-effects caused by not knowing about current illness, past illness or medication.
All information is kept private and confidential.

Patient Name: ________________________________ **DOB** ______________________

Do you have any allergies or are you sensitive to drugs or dressings? ☐ Yes (If yes please list below) ☐ No

Current medications including over the counter vitamins and supplements:

____

Have you ever had, or currently have any of the below? **Please circle.**

- Heart trouble
- Asthma
- Diabetes Type 1 ☐ Type 2 ☐
- Depression or Mental illness
- Epilepsy
- Indigestion or reflux
- Migraine
- Back Pain or arthritis
- Cancer
- Diarrhoea or bowel trouble
- Hep A, Hep B, Hep C
- Hiv

Other illnesses? ________________________________

Family history – Please tick

Mother: ☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke
☐ Colon Cancer ☐ Depression ☐ Breast Cancer

Father: ☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke
☐ Colon Cancer ☐ Depression

Any operations? (please list with dates and any complications) YES or NO

____

____

SMOKING ☐ Non smoker ☐ Ex-Smoker Year stopped __________
☐ Smoker Cigarettes per day: _________ Year started __________

ALCOHOL ☐ Non drinker ☐ Occasional drinker Days per week _________ Standard drinks per day __________

WEIGHT ___________ kgs (if known) HEIGHT ____________ cms (if known)

Women: When did you last have?

Pap smear Date ______________ Was it normal (please circle) Yes or No
Breast Check Date ______________ Was it normal Yes or No

Men: When did you last have an overall check-up? Date __________ ☐ not sure ☐ never