

**58 Middle Street,**

**Chinchilla QLD 4413**

**Phone: 07 4662 7188**

**Fax: 07 4662 7177**

**This information is private and confidential and is for use in your clinical file only**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Personal Details:** | | | | | | |
| **Title** | Mr Mrs Ms Miss Dr Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| **Surname** |  | | **Date of Birth** | | | **/ /** |
| **First Name** |  | | **Middle Name** | | |  |
| **Street Address** |  | | **Preferred Name** | | |  |
| **Suburb** |  | | **Post Code** | | |  |
| **Home Phone:** | | **Mobile Phone:** | | | | **Work Phone:** |
| **Email:** | | | | **Occupation:** | | |
| **Consent to SMS Appointment Reminders?** | | | | | **Yes No** | |
| **Consent to SMS Clinical Communication and Reminders?** | | | | | **Yes No** | |
| **Consent to upload My Health?** | | | | | **Yes No** | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Health Care Details:** | | | |
| **Medicare Number** |   | **Ref Number (next to name):** | **Expiry:** |
| **DVA Gold / White**  (Please Circle) |  | **Expiry Date:** | |
| **Pension Number** |  | **Expiry Date:** | |
| **Concession Healthcare Card** |  | **Expiry Date:** | |
| **Private Health Insurance Fund Name** |  | **Fund Number:** | |

|  |  |  |
| --- | --- | --- |
| **Emergency Contact Details:** | | |
| **Next of Kin (Name):** | **Contact Number:** | **Relationship:** |
| **Emergency Contact (Name):** | **Contact Number:** | **Relationship:** |

**Australia is a genuinely multicultural society. To tailor appropriate care, encourage understanding and appreciation between people from different nationalities and backgrounds please complete this section**

|  |  |
| --- | --- |
|  | |
| **Country of Birth:** | |
| **Do you require a Translator?** Yes No | **Ethnicity:** |
| **To assist with health initiatives – are you Aboriginal or Torres Strait Islander?** (please tick)  Aboriginal Torres Strait Islander Aboriginal & Torres Strait Islander No | |

**Transfer of Medical Records:**

In order to provide you with the best possible care, I agree to the Chinchilla Medical Practice obtaining my records from my previous doctor. RECORDS SENT ON A DISC WILL ONLY BE ACCEPTED IN XML FORMAT

Signature­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

Previous Practice: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current medications (including over the counter medication, vitamins, minerals and/or health supplements):**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you have any allergies or are you sensitive to drugs or dressings?**

Yes (Please specify below) No

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |
| --- | --- | --- | --- |
| **Your Health History: Do you have or have a history of?** (please tick) | | | |
|  | Operations (give details): |  | Hypertension |
|  | Asthma |  | Chronic Illness (give details): |
|  | Diabetes |  | Other (give details): |
| **Do you know your blood group?** Yes No | | **Blood Group:** | |
| **Do you live with a carer?** Yes No | | **Name & Contact:** | |

If this information is for your child please provide a copy of your child’s immunisation history to the receptionist.

|  |  |  |  |
| --- | --- | --- | --- |
| **Family History: Have any members of your family had?** (please tick) | | | |
|  | Diabetes |  | Mental Illness (give details) |
|  | Asthma |  | Cancer (give details) |
|  | Heart Disease |  | Other (give details) |

|  |  |
| --- | --- |
| **Social History:** | |
| Are you a smoker, non-smoker or ex-smoker?  If a smoker, how many per day? \_\_\_\_\_\_\_ | Past smoking history: Nil Light Moderate Heavy  Which year did you stop smoking? \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| How many days per week do you drink alcohol: \_\_\_\_\_ days  How many alcoholic drinks would you have to drink per day: \_\_\_\_\_\_\_\_ drinks | Past drinking history: Nil Light Moderate Heavy  Which year did you stop drinking? \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Females: When did you last have?**  Pap Smear Date: \_\_\_\_\_\_\_\_\_\_\_ Not Sure/Never  Breast Check Date: \_\_\_\_\_\_\_\_\_\_\_ Not Sure/Never | **For those 65 years and older: When was the last time you were immunised?**  Influenza Date: \_\_\_\_\_\_\_\_\_\_ Not Sure/Never  Pneumococcal Date: \_\_\_\_\_\_\_\_\_\_ Not Sure/Never |

At Chinchilla Medical PracticeSorrento Medical Centre we strive to provide high quality care, appropriate to meet our client’s health care requirements.

**By becoming a patient of Chinchilla Medical Practice and signing this new patient form, I agree and consent to the following:**

I consent to the use of my personal health information Chinchilla Medical Practiceand 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. I consent to receive follow up reminders and recalls to be sent to the above address and/or mobile number.

**CANCELLATION POLICY**

Please telephone the surgery to cancel at least 2 hours prior to your appointment. This will allow the doctors to reschedule in another patient who needs to be consulted.

**DID NOT ATTEND APPOINTMENTS –** Any unattended appointments will be noted of; by missing appointments this denies other patients who need to be consulted. Recurrent failed attendance will result in a consultation charge per appointment.

Signature­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

Printed Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (If the patient is under 16 years the parent/guardian is to sign)