

Office Use Only:

- Form Completed
 NP
 Existing



This information is private and confidential and is for use in your clinical file only. It is a requirement that all files contain this information for accreditation purposes. Please print and give as much detail as possible to assist us to provide quality care.

How did you find out about our surgery?

- Word of Mouth Relatives Drive/walk past A frame outside Website
 Yellow pages White Pages Leaflets/flyers School Newsletter Radio
 Bowls Club Holiday Accom Pharmacy Library Card Other: _____

PATIENT DETAILS

Mr Mrs Ms Miss Dr Surname: _____ Given Name: _____ Middle Name: _____

Date of Birth ____/____/____ Ethnicity: Australian Aboriginal TSI ATSI Other _____

Country Of Birth _____

Residential Address: _____ Town: _____ Postcode: _____

Postal Address: (if different to home) _____

Phone: _____ Mobile: _____ Business: _____

Email Address: _____ Do you wish to receive electronic newsletters: Yes No

Medicare No: _____ Ref # (next to name) _____ Expiry: _____

Veterans Affairs No: _____ Gold White - Condition/s: _____

Pension/Healthcare Card No: _____ Expiry: _____

Do you have private health care fund? Yes No Fund Name: _____ Fund Number: _____

Next of Kin: _____ Relationship: _____ Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Current Medications:

Complimentary Medications: (eg. Multivitamin, fish oil etc) _____

Do you have any known allergies? No Yes: _____

SOCIAL HISTORY

Marital Status: Single Married De-facto Widowed Separated

Recreational Activities: _____ Are you an Elite Athlete? Yes No

Accommodation: Own Home Rental Relatives Home Nursing Home Homeless Other

Lives with: Alone Spouse Relative/Parents Friend

Are you a Carer: Yes No Do you have a Carer: Yes No

If Yes : Carer Name: _____

Address: _____

Contact No: _____

PLEASE TURN OVER

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

Past Smoking History: Nil Light Moderate Heavy Which year did you stop smoking? _____

Alcohol Consumption: Do you drink alcohol? Yes No
If yes, how many standard drinks per day: _____ How many days per week: _____

Past Alcohol Consumption: Nil Occasional Moderate Heavy

What is your Occupation? _____ Retired Child

PATIENT HISTORY

Please list any operations or previous illnesses: _____

Do you know your blood group? Yes No If yes, what group are you? _____

FEMALE PATIENTS: Have you ever had a papsmear? No Yes Month: _____ Year: _____

Are you currently breastfeeding? No Yes

FAMILY HISTORY: Unknown (eg. Adopted) No significant family history

Mother: Still alive: Yes No If no, Age at Death: _____ Cause of Death: _____

Diabetes Hypertension Heart Disease Stroke
Colon Cancer Depression Breast Cancer Other Cancer (Please Specify): _____

Father: Still alive: Yes No If no, Age at Death: _____ Cause of Death: _____

Diabetes Hypertension Heart Disease Stroke
Colon Cancer Depression Breast Cancer Other Cancer (Please Specify): _____

Other **immediate** family member's **significant illness:**

Relationship: _____ Condition: _____

Relationship: _____ Condition: _____

Relationship: _____ Condition: _____

Relationship: _____ Condition: _____

At Pelican Waters Family Doctors we strive to provide high quality care, appropriate to meet our clients' health care requirements.

By becoming a patient of Pelican Waters Family Doctors and signing this new patient form I agree and consent to the following:

As part of our reminder service we will SMS you appointment reminders for extended, skin and recall appointments

I consent to the use of my personal health information by the Pelican Waters Family Doctors 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 and/or text message to my mobile phone number.

Please note, if you no longer require your appointment, we would appreciate you calling to cancel so the time may be made available to other patients. Failure to do so, a minimum of 2 hours prior to your appointment, may incur a fee of \$50.00 which is not claimable on Medicare.

Signature: _____ **Date:** _____ / _____ / _____

Printed Name: _____

BE SURE TO FOLLOW US ON FACEBOOK



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