

NEW PATIENT FORM

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		
Postal Address:						
Phone / Home :			Work :			Mobile:
Email Address:				Consent to SMS Reminder?	Yes	No
Preferred Contact Method (Circle):	Home phone	Work phone	Mobile phone	Email	SMS	
Occupation:				Past Occupation:		
How did you hear about us? (Circle)	Google	Health Engine	HotDoc	Facebook	Friend/Family	Mail
	Other, Please indicate _____					

Health Care Details:			
Medicare Number	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Ref Number:	Expiry:
DVA Gold / White (Please Circle)		Expiry Date:	
Pension Number		Expiry Date:	
Concession Healthcare Card		Expiry Date:	

Emergency Contact Details:		
Next of Kin (Full Name):	Contact Number:	Relationship:
Emergency Contact (Full 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:	Ethnicity:
Do you require a Translator? Yes No	
To assist with health initiatives – are you Aboriginal or Torres Strait Islander? (please Circle)	
Aboriginal	Torres Strait Islander
Aboriginal & Torres Strait Islander	No

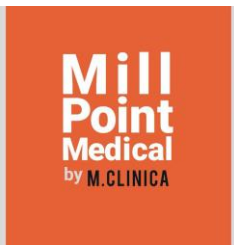
CANCELLATION POLICY

Please telephone the surgery to cancel at least 4 hours prior to your appointment. This will allow the doctors to reschedule in another patient who needs to be consulted; failing to do so will result in a **fee of \$40.00 per 10 minute booking** time allocated. Payment of such fee will be required in full prior to any future appointment booking.

DID NOT ATTEND APPOINTMENTS – Any appointment that is not cancelled and you do not attend or 'no-show' for your appointment, will be dealt with as per our cancellation policy above.

Signature _____ Date _____ / _____ / _____

Please turn over



Mill Point Medical Centre
 2/2 Meadowvale Ave
 South Perth WA 6151
 Phone: 9367 7840
 Fax: 9368 6390
 ABN : 61 615 700 037

Surname: _____ First Name: _____ Date of Birth ____/____/____

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)			
<input type="checkbox"/>	Operations (give details):	<input type="checkbox"/>	Hypertension
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Chronic Illness (give details):
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Other (give details):
<input type="checkbox"/>	Do you know your blood group?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Blood Group:
<input type="checkbox"/>	Do you live with a carer?	Yes <input type="checkbox"/> No <input type="checkbox"/>	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) Please specify which family relation e.g. mother father, grandmother etc.			
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Mental Illness (give details)
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Cancer (give details)
<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	Other (give details)

NOTE: This section may not be applicable for some patients.

Social History:			
<input type="checkbox"/>	Do you smoke?	Yes: ____/day <input type="checkbox"/> No <input type="checkbox"/>	Past smoking history: Nil Light Moderate Heavy Which year did you stop smoking? _____
<input type="checkbox"/>	Do you drink alcohol?	Yes: ____/day <input type="checkbox"/> No <input type="checkbox"/>	Past drinking history: Nil Light Moderate Heavy Which year did you stop drinking? _____
<input type="checkbox"/>	Females: When did you last have?		For those 65 years and older: When was the last time you were immunised?
<input type="checkbox"/>	Pap Smear	Date: _____ Not Sure/Never <input type="checkbox"/>	Influenza Date: _____ Not Sure/Never <input type="checkbox"/>
<input type="checkbox"/>	Breast Check	Date: _____ Not Sure/Never <input type="checkbox"/>	Pneumococcal Date: _____ Not Sure/Never <input type="checkbox"/>

At Mill Point Medical Centre we strive to provide high quality care, appropriate to meet our client's health care requirements.

By becoming a patient of Mill Point Medical Centre and signing this new patient form I agree and consent to the following:

- I consent to the use of my personal health information by Mill Point Medical Centre 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 through my preferred method of contact.

Signature _____ Date ____/____/____

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