New Patient Form

Chinchilla Medical Practice

Phone: 07 4662 7188
Fax: 07 4662 7177

This information is private and confidential and is for use in your clinical file only
Doctors at this practice use Pen CS Software to help provide you with the best medical care.

Personal Details:			
Title	Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other: _____		
Birth Sex	Male / Female (please circle)	**Gender Identity**	Male / Female / Transgender / Different Identity
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 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 ever had diabetes, asthma, heart disease, cancer etc? (please list)			
Mother's side		**Father's side**	

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 Practice 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 Practice 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. 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)