New Patient Form

Welcome. Please take care in providing your details accurately.

MC MEDICAL & DENTAL

Title: _____ Given Names: _____ Surname: _____

Date of birth: ____/____/____ Gender: (Please tick) ☐ Male ☐ Female ☐ Intersex/Other

Known as: _____

Medicare No. _____ Ref No.____ Exp. Date _____ Private Health Fund_____

Concession or Veterans Affairs # _____ Exp. Date _____

Home Address: _____*include apartment no.

Phone: _____ Mobile: _____

Email: _____

Marital Status ☐ Single ☐ Married ☐ De-facto ☐ Separated ☐ Divorced ☐ Widowed

Occupation _____ Employer _____

We collect this information in case of emergency:

Next of kin:

Name: _____ Relationship to you: _____

Phone: _____ Mobile: _____

Emergency contact (if different to above):

Name: _____ Relationship to you: _____

Phone: _____ Mobile: _____

YOUR HEALTH INFORMATION

HEIGHT _____cm WEIGHT _____ kg

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

☐ Yes ☐ No ☐ Unsure

If Yes, details _____

Reaction _____

CURRENT MEDICATIONS (please specify the name and dosage of your medication):

_____

_____

SOCIAL HISTORY:

Smoke ☐ Non smoker

☐ Ex-smoker Year started _____ Year stopped _____

_____ /day

☐ Smoker _____ / day Year started _____

Alcohol How often do you have a drink containing alcohol?

☐ Never ☐ monthly or less ☐ 2-4 times/month ☐ 2-3 times/week ☐ ≥4 times/week

How many standard drinks containing alcohol do you have on a typical day?

☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 to 9 ☐ ≥10

How often do you have 6 or more drinks on one occasion?

☐ Never ☐ less than monthly ☐ Monthly ☐ Weekly ☐ Almost daily

Are you concerned about your drinking?

☐ Yes ☐ No ☐ Don't know

SIGNIFICANT FAMILY HISTORY: ☐ Nil known ☐ Unknown

Mother ☐ Diabetes ☐ Hypertension ☐ Heart disease ☐ Stroke

☐ Colon cancer ☐ Depression ☐ Breast cancer

Father ☐ Diabetes ☐ Hypertension ☐ Heart disease ☐ Stroke

☐ Colon cancer ☐ Depression ☐ Prostate cancer

PERSONAL HEALTH HISTORY: Do you have, or have you had any medical condition? (e.g. Diabetes, hypertension, heart disease, asthma, cholesterol, cancer or operations)

_____

_____

HEALTH INITIATIVES

Australia is a genuinely multicultural society. To assist us in providing appropriate health initiatives, please answer the following:

Are you Aboriginal or Torres Strait Islander?

☐ Yes- Aboriginal ☐ Yes- Torres Strait Islander ☐ Yes – Aboriginal and Torres Strait Islander ☐ No

Country of Birth _____ Year of arrival in Australia _____

Preferred Language _____ **Interpreter required** ☐ Yes ☐ No

Privacy Statement

MC Medical and Dental is committed to maintaining the confidentiality of your personal health information. Your medical record is a confidential document. This practice has a policy to maintain security of personal health information at all times, and to ensure that this information is only available to authorized members of staff. We have a more comprehensive Privacy Policy that you are welcome to read upon request.

Payment Policy

Full payment is required after your consultation via Cash or EFTPOS/credit card, if you have any questions regarding your payment please speak to Reception staff.

Results and Reminders

Our practice uses a reminder system to improve the quality of your health care. The practice may send you an SMS to ask you to make an appointment regarding **your test results**. The practice also sends reminders by mail, telephone or SMS for procedures such as vaccinations, pap smears and other health reviews that you may be due for.

I wish to be included in your clinical reminder system:

Please tick one: ☐ Yes ☐ No

We ask patients to book follow-up appointments to review any test results before being discharged from care. Please note that results can only be given to you by your GP. Please refrain from asking for them by telephone or email. Please advise the practice if you are unable to proceed with any recommendations (referral, management plans, etc.) so that other arrangements can be made for you.

My Health Record Consent

Do you consent to uploading clinical documents to your My Health Record? (except for scripts) ☐ Yes ☐ No

Signature of patient or guardian _____ Date ____ / ____ / ____

If you are completing this form for your child (under 16),please ask the receptionist for the additional payee form.