New Patient Information Form

We are committed to providing our patients with the best care. To do this, it is essential that your health record contains complete and accurate information. If any information should change, please call our reception to inform us. **Please note, information with an * must be provided**

Title *		Date of Birth *			
Given Names *					
Surname *					
Street Address*					
Suburb *			Postcode		
Birth Sex* (F/M)		**Pronouns***		Gender Identity*	
Email *					
Mobile Number*					
Occupation *					

Next of Kin Information *

Name:	
Phone number:	
Relationship to you:	

Emergency Contact Information *

Name:	
Phone number:	
Relationship to you:	

Cultural Identity*

Country of Birth	
Do you identify as Aboriginal and/or Torres Strait Islander? *(please tick)*	o No o Yes – _____
Do you require and interpreter service? *(please tick)*	Yes / No *(please circle)*

Patient History

Do you wish to make Wyperfeld Medical Clinic your regular GP?	Yes / No *(please circle)*
Previous GP/Medical centre *(if applicable)*	

Health Identifiers*

Medicare number	Ref	Expiry date
Dept of Veteran's Affairs File number		Gold / White *(please circle)*
Concession (Pension/Health Care) Card Number		Expiry date
Private Health insurance details		

DOCTORS
TAYLORS LAKES

Your Health information *

Do you have any allergies or are you sensitive to drugs or dressings? Yes / No *(please circle)*

_____

Current medications – Please list all current medications, including complementary and over-the-counter medicines.

_____

_____

Medical History – do you have, or have you had a history of the following? Please provide details

- o Surgery
- o Asthma
- o Diabetes
- o Hypertension
- o Chronic Illness
- o Other: _____

Lifestyle risk factor information

Smoking: Yes / No *(please circle)*

If Yes, – how many _____ day/____week

Alcohol: Yes / No *(please circle)*

If Yes, – how many _____ day/____week

Recreational Drugs: Yes / No *(please circle)*

If Yes, – how many _____ day/____week

Family health history information – have any members of your family had… *(please tick)*

- o Heart disease
- o Asthma
- o Diabetes
- o Mental Illness
- o Hypertension (high blood pressure)
- o Cancer – type:
- o Other _____

How did you hear about us?

_____

I AGREE TO ALLOW WYPERFELD MEDICAL CLINIC TO COLLECT INFORMATION RELEVANT TO MEDICAL CARE AND TREATMENT FROM THE DOCTORS. I CONSENT TO THE USE OF MY MOBILE NUMBER FOR SMS OR EMAIL TO CONTACT ME FOR REMINDERS, RECALLS, HEALTH ALERTS, AND/OR HEALTH NEWSLETTERS. FULL PRIVACY STATEMENT IS AVAILABLE ON REQUEST.

Patient sign: _____

Date: _____