newport doctor

New patient Form

Title: (circle) Mr Mrs Ms Miss Dr Prof Mast.

First name:_____ Surname:_____ Preferred Name_____

Date of Birth:___/___/____ Gender: (circle) Male Female Other Occupation _____

Address: _____

State_____ Postcode_____ Ethnicity / Country of birth_____

Phone:_____ Work_____ Mobile_____

Email:_____

Newport Doctor uses **unencrypted email** and therefore there is a risk of a third party accessing this information. Email senders can easily misaddress an email or unintended recipients can receive email. Newport Doctor will use reasonable means to maintain security and confidentiality but cannot guarantee the security and confidentiality of email communications and Newport doctor will not be liable for the inadvertent disclosure of confidential information.

Consent to email correspondence Yes ☐ No ☐

Postal Address: (if different from above)_____

Do you identify as being Aboriginal and/or Torres Strait Islander?

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

Health Identifiers:

Medicare Number:_____ Position on card:_____ Expiry:_____/_____

Dept. of Veterans' Affairs File Number:_____☐ Gold ☐ White

Pensioner Concession Card or Health Care Card No:_____ Expiry: _____/_____

Next of kin / Emergency contact:

Name:_____ Relationship to you_____

Home Phone:_____ Mobile _____ Work_____

Current Medications- please list all current medication, including complementary and over-the-counter medicines (e.g. homeopathic medicines such as vitamins and minerals)

_____

_____

Medical History- Do you have or have you had a history of the following

☐ Surgery / fractures- provide details_____

☐ Asthma ☐Diabetes ☐ Hypertension ☐ Cancer

☐ Chronic or Major Illness (please list)_____

☐ Other (provide details)_____

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Immunisations:

☐ Childhood vaccination up to date ☐ Tetanus- Date_____ ☐ Whooping Cough-Date_____

Family Health History: Have any members of your family have-

☐ Heart Disease ☐ Asthma ☐ Diabetes ☐ Hypertension (high blood pressure) ☐ Mental Illness ☐ Cancer

☐ Other significant - provide details:_____

Life Style Information-

Do you engage in regular exercise (walking, running, swimming, gym)? Yes ☐ No ☐

Smoking

☐ No ☐ Former Smoker – Quit date_____ ☐ Yes – how many _____day / _____week

Alcohol

☐ No ☐ Rarely – how often_____ ☐Yes – how many _____day /_____ week

Women's Health

Last Cervical Screen:_____ Last Breast Check / Mammogram_____

Men's health

Last prostate check (if aged over 50)_____ Last general check up_____

Which is the best way to contact you for reminders and recalls?

1. By home phone ☐ 2. By Mobile ☐ 3. Work Phone ☐

Consent to SMS reminders? Yes ☐ No ☐

2.

By signing below, you (as a patient/parent/guardian) are consenting to the collection of your personal information, and that it may be used or disclosed by the practice for your health care management. (E.g Specialist, pathology, immunisation register). Your personal information will only be used for the purposes for which it was collected in Accordance with the Privacy Act 1988.

Patient signature or Parent / Guardian (if child is under 16)

Signature: _____

Name:_____ Date:_____