Lifelong Healthcare

NEW PATIENT FORM

DO YOU REQUIRE A TRANSLATOR? YES ☐ NO ☐

TITLE: _____ FAMILY NAME: _____ GIVEN NAME: _____

DATE OF BIRTH: _____ / _____ / _____ GENDER: _____

STREET ADDRESS: _____

SUBURB: _____ POSTCODE: _____

POSTAL ADDRESS ☐ SAME AS ABOVE

STREET ADDRESS: _____

SUBURB: _____ POSTCODE: _____

EMAIL: _____

MOBILE PHONE: _____ HOME PHONE: _____

WORK PHONE: _____

DO YOU CONSIDER YOURSELF TO BE OF

☐ ABORIGINAL ORIGIN?

☐ TORRES STRAIT ISLANDER ORIGIN?

☐ ABORIGINAL AND TORRES STRAIT ISLANDER ORIGIN?

ETHNICITY: _____

MEDICARE NUMBER: Reference Number

☐☐☐☐☐☐☐☐☐☐ ☐

EXPIRY DATE: _____ / _____

DVA NUMBER: _____

EXPIRY DATE: _____ / _____

DO YOU HOLD ANY OF THE FOLLOWING CARDS?

☐ PENSIONER CONCESSION CARD

☐ HEALTH CARE CARD

☐ COMMONWEALTH SENIORS HEALTH CARD

CARD NUMBER: _____

EXPIRY DATE: _____ / _____

TYPE OF HCC? _____

EMERGENCY CONTACT: (used only in the event of an emergency)

NAME: _____ RELATIONSHIP: _____

PHONE NUMBER: _____

NEXT OF KIN: ☐ SAME AS EMERGENCY CONTACT

NAME: _____ RELATIONSHIP: _____

PHONE NUMBER: _____

Non-Attendance Fee.

We understand that at times you may not be able to make your appointment.
We kindly ask that you notify the practice at least one hour before to cancel your appointment, if you fail to do so you may incur a non-attendance fee.
We appreciate and thank you for your understanding.

I have read and understood this policy.

Signature _____

Research Medical Centre

PRIVACY

Your private information is at all times treated confidentially with care and in accordance with the Australian Privacy Principles (APPs). A copy of our privacy policy is available on request.

I consent to receiving appointment reminders via SMS. ☐ YES ☐ NO

I consent to receiving Recall Reminders via SMS. ☐ YES ☐ NO

I understand it is my responsibility to ensure all personal contact information is current and correct.

You can update your details at any time with our reception staff.

Personal & Health Information Consent

We respect your rights to privacy and takes our privacy obligations seriously. We comply with the Australian Privacy Principles, found under the Privacy Act 1988 (Cth). Our Privacy Policy can be obtained from:

- www.nillmc.com.au
- Reception
- By calling (03) 8432 3333

We require your consent to collect personal information and health information about you. Please read this information carefully, and sign where indicated below.
Research Medical Centre collects information from you for the primary purpose of providing you healthcare services. We require you to provide us with your personal and health information such as your medical history so that we may provide our services to you. We will also use the information you provide in the following ways:

- Appropriately manage our practice, such as conducting audits and undertaking accreditation processes, manage billings and training staff;
- Effectively communicate with third parties, including Medicare Australia, private health insurers, government departments and other practitioners involved in your healthcare.

I have read the information above and understand why my information is collected and how it is used. I acknowledge that I am not obliged to provide any information requested of me, but that failure to do so might compromise the quality of care provided to me.

Patient/Guardian Name: _____ Date: ____/___/___

Patient/Guardian Signature:_____

Guardian Relationship: _____

Lifelong Healthcare

NEW PATIENT FORM

CONFIDENTIAL MEDICAL HISTORY QUESTIONNAIRE

(Once completed, please hand this section of the questionnaire directly to you Doctor)

Patient Name:_____

Date of Birth: _____

Past Medical History Have you suffered from any of the following – currently or previously?

□ Heart problems	□ Stroke	□ High blood pressure	□ Blood clots	□ Glaucoma
□ Epilepsy	□ Anxiety / depression	□ Asthma	□ Bronchitis	□ Diabetes
□ Back Pain	□ Eye problems	□ Thyroid problems	□ Hep C	□ Hep B
□ Liver disease	□ Kidney disease	□ Osteoporosis	□ Fractures	□ Arthritis
□ Hearing loss	□ Migraines	□ Skin conditions	□ Cancer	□ HIV
□ High Cholesterol	□ Any other _____			

Preventative Health: Please tick the boxes where appropriate

ALL	FEMALES	MALES	Any illnesses, operations or hospital admissions
Bowel screening □ Date:	Pap smear □ Date:	Prostate check □ Date:	
Skin Check □ Date:	Mammogram □ Date:	Testes check □ Date:	
Unintended weight change □ _____KG since (date) _____	Health check □ Date:	Health check □ Date:	
	Immunisations:	Immunisations:	

ALLERGIES

_____

_____

_____

_____

_____

_____

SMOKING STATUS

- □ SMOKER
- □ NON SMOKER
- □ EX SMOKER
- □ QUIT DATE _____

ALCOHOL AND SUBSTANCE STATUS

- □ NON DRINKER

STANDARD GLASSES PER WEEK _____

STANDARD GLASSES PER DAY _____

- □ RECREATIONAL DRUGS

SPECIFY _____

FAMILY HISTORY	MOTHER Alive □	FATHER Alive □	SIBLINGS
Heart attack	□	□	□
Bowel cancer	□	□	□
Breast cancer	□	□	□
High blood pressure	□	□	□
Stroke	□	□	□
Arthritis	□	□	□
Blood clot/s	□	□	□
Depression	□	□	□
Diabetes	□	□	□
Thyroid disease	□	□	□
Haemachromatosis	□	□	□
Osteoporosis	□	□	□
Other:			

SOCIAL HISTORY

□ MARRIED □ SINGLE

□ DIVORCED □ DE-FACTO

OCCUPATION

_____

MEDICATIONS

Please include ALL tablets, inhalers, patches, gels or injections – as well as any other "natural" remedies or supplements.

MEDICATION	DOSE	FREQUENCY

OFFICE USE ONLY

Data entered by (initials) ___