CLAREMONT MEADOWS
FOR YOUR BETTER HEALTH

New Patient Information Sheet

Please fill out ALL content of the form to ensure we can provide the best possible care available.

Title _____ Surname _____Given Names _____

Known as _____Date of Birth _____/_____/_____ ☐ Male ☐ Female ☐ L.G.B.T

Place of Birth: ☐ Australia ☐ _____ Another Ethnicity: _____

Are you Aboriginal or Torres Strait Islander descent? Yes/ No or Both

Home Address:

_____

Suburb: _____State: _____ Postcode: _____

Phone: (Home) _____(Work) _____ (Mobile) _____

Email: (we may use this to contact you) _____

Medicare No: __ __ __ __ __ __ __ __ __ __ Ref No: 1 2 3 4 5 Valid To: _____/_____

Concession Card: ☐ Pension ☐ Health Care Card ☐ Veterans Affairs Gold / White

Card No: _____**Exp**. _____/_____/_____

Occupation: _____ Employer_____

Next of Kin (if same address, please write 'as above') please write clearly

Name:_____Relationship to you:_____

Address_____Suburb & Post Code_____

Phone: (Home) _____ (Work) _____ (Mobile) _____

Emergency Contact (if same address, please write 'as above') *please write clearly*

Name:_____Relationship to you:_____

Address: _____Suburb & Post Code_____

Phone: (Home) _____ (Work) _____ (Mobile) _____

Any allergies? (including drugs and dressings) ☐ NIL known allergies.

What illness or operations have you had in the past?

CURRENT MEDICAL PROBLEM (What is the reason for today's visit?)

How do you know about our Clinic? ○ Website ○ Facebook ○ Word of Mouth ○ Others……

Please turnover to complete other side

FAMILY HISTORY (Have any of your parents, brothers or sisters had the following)				
Father: □ Melanoma □ Hypertension □ Prostate Cancer	□ Diabetes □ Depression □ Other Information:	□ Heart Attack □ Migraine	□ Stroke □ Asthma	□ Bowel Cancer □ Breast Cancer
Mother: □ Melanoma □ Hypertension □ Ovarian Cancer	□ Diabetes □ Depression □ Other Information:	□ Heart Attack □ Migraine	□ Stroke □ Asthma	□ Bowel Cancer □ Breast Cancer
Women Only:	Births:	Dates:	Any Complications:	

CURRENT MEDICAL STATUS (Do you have any current long-term conditions? E.g. Heart disease, diabetes, cancer etc).

MEDICATIONS (Please state any tablets or medicines you take)

Name	Dose	Reason

SOCIAL

Smoking	□ Non-Smoker	□ Ex-Smoker	□ Smoker	Amount per day _____
Alcohol	□ Non-Drinker	□ Social Drinker	□ Moderate Drinker	□ Heavy Drinker
Exercise	□ Nil	□ Regular Exercise	□ Moderate Exercise	□ Elite Athlete

IMMUNISATIONS

Are Childhood Immunisations up to date? □ No □ Yes
Do you have a yearly flu injection? □ No □ Yes

Date of your last Tetanus Injection? _____ / _____ / _____
Date of your last Pneumonia Injection? (over 65 yrs) ___ / ____/___

Claremont Meadows Medical Centre requires your consent to collect personal information about you. Please read consent form carefully.

Please refer to our clinic health information collection disclosure consent details description in separate page.

Patient Consent

- I, _____, have read the information above and understand the reasons why my information must be collected, and the purposes for which my information may be used or disclosed or shared with other professionals (e.g. doctors, specialists, allied health professionals) inside and outside Claremont Meadows Medical Centre. I understand that if my information is to be used for any purpose other than that set out above, my further consent will be obtained.
- I, _____ give permission to receive SMS reminder (phone call if necessary) for appointments, treatment, preventive cares.
- I understand that only my relevant personal information will be provided/disclosed to allow the above actions to be undertaken and I am free to withdraw, alter or restrict my consent at any time by notifying this practice in writing.
- I am aware of clinic's no show policy which is fees of $50 is chargeable after 3rd time missed appointments.

Patient name: (please print) _____

Signature: _____ Date: _____

If not patient signing - your name (please print) _____

Your relationship to patient (e.g. Mother, Father, guardian) _____