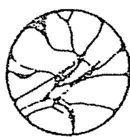


Welcome to

Glen Forrest Medical Centre

NEW PATIENT FORM

To provide you with the best quality of care we require this information.
If some questions or answers are difficult or cause stress or feel intrusive, please leave those sections blank.

PATIENT DETAILS

Title: Mr / Mrs / Miss / Ms / Master / Dr

Surname: ______________________ First Name: ______________________

Middle Name: ______________________ Preferred Name: ______________________

Date of Birth: _____/_____/______ Male / Female

Country of Birth ______________________

To assist with health initiatives are you Aboriginal ☐ or Torres Strait Islander ☐

As Australia is a genuinely multicultural society, and to tailor appropriate care, encourage understanding and appreciation between people from different nationalities and cultures – Do you identify as someone from culturally and/or linguistic diverse background? ☐ No ☐ Yes –

If yes, please elaborate ______________________
If yes, do you require an interpreter service? ☐ Yes ☐ No

Street Address: ______________________

Postal Address: ______________________

Phone: (h) ______________________ (wk) ______________________

(mb) ______________________ Email Address: ______________________

Preferred method to contact you (please circle): mb / work / home / sms / email / letter

Would you like to be reminded of your appointment via SMS Yes / No

Occupation: ______________________ Usual Doctor: ______________________

CARD HOLDERS (please mark box)

Holder of: Pension Card ☐ or Health Care Card ☐ or

DVA Card Gold ☐/ White☐ (if white card, condition/s: ______________________) or

Commonwealth Seniors Card☐

Card Number: ______________________ Expiry Date: ______________

PRIVATE HEALTH FUND

Private Health Fund: Yes / No Fund Name: ______________________

NEXT OF KIN

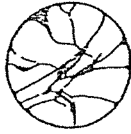
Full Name: ______________________ Relationship to Patient: ______________

Phone: (h) ______________ (w) ______________ (mb) ______________

EMERGENCY CONTACT

Full Name: ______________________ Relationship to Patient: ______________

Phone: (h) ______________ (w) ______________ (mb) ______________



Welcome to

Glen Forrest Medical Centre

CONSENT:

1. I consent to the inclusion on the Glen Forrest Medical Centre recall reminder register and acknowledge that I may receive correspondence by telephone, post, sms or email for follow up visits requested by the doctor, appointment reminders, medical updates and health information.
2. I am in receipt of a Glen Forrest Medical Centre Practice Information Sheet.
3. I acknowledge that Glen Forrest Medical Centre charges a fee for Failure to Attend.
4. I acknowledge that Glen Forrest Medical Centre is a Private Billing Practice.

Signature of patient or guardian: ______________________ Date: ____________

Allergies

Do you have any allergies to any medications: Yes / No

Name of Medication/s: ____

If yes, what are your reactions: Anaphylaxis / Rash / Vomiting / pain/ or other

If other, please explain ____

Do you have any other allergies eg Bees or food: Yes / No

What are your reactions: Anaphylaxis / Rash / Vomiting / pain/ or other

If other, please explain ____

Health History – Do you have or had a history of?

Operations ☐ Asthma ☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐

Stroke ☐ Mental Health ☐ Cancer ☐ if yes, details ____________________

Details of past medical problems/issues:

____

____

Are you taking any current medication? Yes / No

If yes, Details ____

____

Over the counter medications? Yes / No

If yes, Details: ____

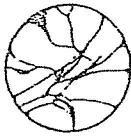
____

Vaccinations up to date Yes / No

Date of last Tetanus Booster: ____ / ____ / _____

BILLING

Please note that we are a private billing practice and accounts are paid on the day. We can claim your Medicare rebate immediately back to you using Easyclaim. However, Glen Forrest Medical Centre will bulk bill VETS Patients, children 12 years and under, INR and flu vaccinations only. Pensioners and children over 12 years are billed a discounted rate. **Doctors can vary their fees according to an individual's circumstances. Please discuss this with the Doctor.**



Welcome to

Glen Forrest Medical Centre

Family History

Mother Is she still alive? Yes/No If no, age of death ___ and cause ____________

Asthma ☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Cancer ☐
Mental Health ☐

If yes, details ____

____

Father Is he still alive? Yes/No If no, age of death ___ and cause ____________

Asthma ☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Cancer ☐
Mental Health ☐

If yes, details ____

____

Siblings/Grandparents(please specify relation in space provided)

Asthma ☐ __________ Diabetes ☐ __________Hypertension ☐ __________

Heart Disease ☐ __________ Cancer ☐ __________Mental Health ☐ __________

If yes, details ____

____

Alcohol (please circle) **Yes / No / Casual Drinker** *If yes or casual drinker, please specify*

Days per week: ____ *Drinks per day:* ____ *or Monthly/Yearly Amount* ______________

Smoking(please circle) **Yes / No** *If yes, please specify*

Ex-Smoker *- Date of last smoke* ____________ *Duration of smoking?* ____________ *yrs*

Smoker *– Type* ______________ *Daily Amount* __________ *How many years* ______

If you have an injury is it work related? Yes / No

If yes, details ____

There could be other illnesses you have had which you do not want to write down eg termination of pregnancy or sexual infections let the doctor know during the consultation. This also applies to using recreational drugs such as marijuana, speed and heroin. All information will be kept confidential.

Thank you. All information on this form will be treated with the strictest confidence.