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: _____

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) _____

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CONSENT:

1. I consent to receive the following electronic reminders/messages:

   ☐ Appointments ☐ Clinical Communication (Results & Clinical messages)

   ☐ Clinical Reminders ☐ Health Awareness (Leaflets & Database search)

   My Preferred contact method for all communication is:
   ☐ Phone ☐ Letter ☐ SMS (Possible future ☐ App ☐ Email)

2. I acknowledge that the practice will use contact details provided by me (as updated by me from time to time) to communicate with me. To the extent that the mobile number I have provided to this general practice is utilised by more than one patient, I understand and consent that all SMS and phone communications will be directed to that number.

3. I acknowledge that emails are not Glen Forrest Medical Centre's preferred method of communication.
4. I am in receipt of a Glen Forrest Medical Centre Practice Information Sheet.
5. I acknowledge that Glen Forrest Medical Centre charges a fee for Failure to Attend.
6. I acknowledge that Glen Forrest Medical Centre is a Private Billing Practice.

Signature of patient or guardian: _____ Date: _____

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.**

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:

_____

_____

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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: ____ / ____ / _____

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.