

**This information is private and confidential and is for use in your clinical file only**

**NEW PATIENT DETAILS -**  **Please print and give as much detail as possible to assist us to provide quality care.**

Full name: Mr Mrs Ms Miss Dr Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Name: \_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_/\_\_\_\_/\_\_\_\_\_ Ethnicity: Aboriginal TSI ATSI Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Country of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Suburb: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postcode: \_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Business: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_contact at work yes/no

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you consent to SMS contact?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medicare or Vet Affairs No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ref no \_\_\_\_\_\_\_ (next to name) Exp\_\_\_\_\_\_\_\_\_\_\_

Pension/Healthcare Card No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Exp\_\_\_\_\_\_\_\_\_\_\_

Next of Kin \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Person\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Phone No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile Phone No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­\_\_\_\_ Business: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Method of Contact (please circle): Mobile SMS Email Home Phone Work Phone

**By becoming a patient of Sorrento Medical Centre and signing this new patient form I agree and consent to the following:**

I consent to the use of my personal health information by Sorrento Medical Centre and other health care providers involved in my medical treatment and health care within this centre.

I consent to the disclosure of my personal health information by the above named practice to other health care providers involved directly or indirectly involved in my personal health care or medical treatment.

As part of preventative health services offered by this practice we send out follow up reminders and recalls when routine investigations are due. I consent to receive follow up reminders and recalls to be sent to the above address.

Signature­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

Printed Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE TAKE THIS SECTION TO DOCTOR**

Full name: Mr Mrs Ms Miss Dr Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Name: \_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_/\_\_\_\_/\_\_\_\_\_

Current Medications and Doses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any known allergies and your reactions or list nil known if none: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any operations or previous illnesses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FEMALE PATIENTS**: Date of last Pap Smear:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Result:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SOCIAL HISTORY:** Please circle the most appropriate answer fill out all other areas

Do you drink alcohol? Yes No Days per week? \_\_\_\_\_\_\_\_\_\_\_Drinks per Day\_\_\_\_\_\_\_\_\_\_

Past Alcohol History: Nil Light Moderate Heavy

Do you smoke? Yes No If yes how many per day ? \_\_\_\_\_\_\_\_\_\_ Past Smoking History: Nil Light Moderate Heavy

Which year did you stop smoking? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY HISTORY:** Please circle the most appropriate answer fill out all other areas

Family History: Unknown (eg Adopted) No significant family history Other – see list below

**Mother**: Still alive: Yes No If no Age at Death: \_\_\_\_\_\_\_\_\_

Diabetes Kidney Disease Asthma High Blood Pressure Heart Problems Breast Cancer Stroke Depression Epilepsy Other Cancer

**Father**: Still alive: Yes No If no Age at Death: \_\_\_\_\_\_\_\_\_

Diabetes Kidney Disease Asthma High Blood Pressure Heart Problems Stroke Depression Epilepsy Other Cancer

Other immediate family members significant illness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you know your blood group? Yes No If yes what group are you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

At Sorrento Medical Centre we strive to provide high quality care, appropriate to meet our client’s health care requirements.

How did you find out about our surgery?

Word of Mouth White Pages Yellow pages Relatives Drive/walk past Google Leaflets/flyers Pharmacy Other