KEDRON WAVELL MEDICAL CENTRE

New Patient Registration Form

Title: Mr / Mrs / Ms / Mast / Miss / Dr /Other: ______________

Family Name: ____

Given Name: ______________________________________

Middle Name: ______________________________________

Preferred Name: ____________________________________

Date of Birth: ____/____/________

Birth Sex: Female / Male / Other

Gender Identity: Female / Male / Non-binary / Gender Diverse / Transgender / Different Identity

Pronouns:
- ☐ She/Her/Hers
- ☐ He/Him/His
- ☐ They/Them/Theirs

Ethnicity: ☐ Australian ☐ Aboriginal ☐ Torres Strait Islander ☐ ATSI ☐ Other: __________________________

Country of Birth:_____________________________________

Preferred Language:_________________________________

Do you require the use of an interpreter? ☐

Address: ____

____

Suburb: __________________________ **Postcode:** ________

Postal Address: ☐ Same as above ______________________

____

Suburb: __________________________ **Postcode:** ________

Home No: ________________ **Work No:** ________________

Mobile: ____

Preferred contact: Home / Work / Mobile

Email: ____

Medicare Number: ☐☐☐☐☐☐☐☐☐☐

Ref: ☐ **Expiry:** ☐☐ / ☐☐

Do you have a concession card?

Concession: ☐☐☐ ☐☐☐ ☐☐☐ ☐

Expiry: ☐☐ / ☐☐

Type:
- ☐Pensioner
- ☐Health Care Card
- ☐Commonwealth Seniors Health Card

DVA: ☐☐☐☐☐☐☐☐

Type: ☐ Gold

☐ White – Conditions: ______________________

Do you have private health insurance?

Fund Name: ________________ **Fund #**_____________

Next of Kin: _______________________________________

Relationship: _________________________________

Phone: ______________________________________

Emergency Contact: _______________________________

Relationship: _________________________________

Phone: ______________________________________

Your Occupation: ________________________________

Consent

- Kedron Wavell Medical Centre is a private billing practice and provides both telehealth and clinic consultations. Patients are encouraged to attend the practice for an appointment to discuss their investigation results. Use of the treatment room incurs additional fees. Accounts are to be settled on the day of consultation.
- Our practice uses a reminder system to help you maintain your health. The practice sends reminders by SMS, post and telephone for procedures such as vaccinations, cervical screening tests and other health reviews.
- We also use a SMS service for appointment reminders and patient recalls. Please advise reception if you wish to opt out.
- I have read and understood the Kedron Wavell Medical Centre Privacy Policy and I also understand that I am not obliged to provide any information requested of me, but my failure to do so, might compromise the quality of health care and treatment given to me.
- KWMC participates in the Australian Government's PIP QI Incentive arrangement. For more information, please visit https://www.health.gov.au/resources/publications/practice-incentives-program-quality-improvement-incentive-consumer-fact-sheet
  If you would like to opt out of participating in this program, please advise reception.
- KWMC may disclose contact information to a debt collector or collecting services for outstanding balances of 30 days or more.

Signature: ________________________________ Date: _________________

PLEASE CONTINUE TO NEXT PAGE

Name: ____ **DOB:** ____________________

Current Medications:

____

Complementary Medications: (e.g. multivitamin, fish oil etc.)

____

Do you have any known allergies? ☐ No ☐ Yes:

____

PERSONAL MEDICAL HISTORY: Have you ever had any of the following conditions? (Tick if yes)

☐ Heart (e.g. heart attack, arrhythmia, valve problem):

____

☐ Respiratory (e.g. asthma, COPD):

____

☐Gastrointestinal (e.g. reflux, inflammatory bowel disease):

____

☐ Mental Health (e.g. depression, anxiety, PTSD):

____

☐ Other (Please list):

____

SURGICAL HISTORY:

____

FAMILY HISTORY:

____

SCREENING HABITS

Date of Last: Skin Check: ______________________ Bowel Cancer Screen: ______________________

Female Patients:

Have you had a Cervical Screening Test (Pap Smear) before? ☐ No ☐ Yes – When? ____________

Are you currently breastfeeding? ☐ No ☐ Yes

SOCIAL HISTORY

Marital Status: ☐Single ☐Married ☐De Facto ☐ Widowed ☐Separated **Are you an Elite Athlete?** ☐Yes ☐No

Accommodation: ☐ Own Home ☐ Rental ☐ Relative's Home ☐ Nursing Home ☐ Homeless ☐ Other

Lives with: ☐ Alone ☐ Spouse ☐ Relative/Parents ☐ Friend **Are you a Carer?:** ☐ Yes ☐ No

Do you have a Carer?: ☐ Yes ☐ No If yes – **Carer Name**: ______________________________

Address: ______________________________ **Contact No:**______________________________

Number of Children: __________ **Number of Grandchildren:** ______________

Do you drink Alcohol? ☐ Yes ☐ No If yes, how much per week?______________________________

Do you smoke? ☐ Yes ☐ No If yes, how many per day?______________ Start Year:______________