Kedron Wavell Medical Centre

New Patient Registration Form

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

Given Name: _____

Middle Name: _____

Family 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: _____

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: _____

Do you require the use of an interpreter? If so, which language? _____

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:_____