New Patient Information Form – please complete all 3 pages

We are committed to providing our patients with the best care. To do this it is essential that your health record is accurate.

Can you please assist us by completing the following:

Title (e.g. Mr/Mrs/Ms/Miss)			
Surname			
Given Names			
Date of Birth			
Address			
Home Phone			
Work Phone			
Mobile Phone			
Email			
Consent for contact via Email or SMS	I hereby consent for staff at Dubbo Family Doctors to contact me via Email or SMS (Text Message) Signature :		
Medicare Number and Place on Card		**Expiry Date**	
DVA Number Gold or white?		**Expiry Date**	
Pension Number		**Expiry Date**	
Health Care Card Number		**Expiry Date**	
Private Health Fund		**Number**	
Emergency Contact	Name: Home phone: Mobile phone:	Relationship to you: Work phone:	

Reminder Systems:

As a standard part of our provision of high quality care , our practice provides our patients with preventative care and health review reminders e.g. immunisations, pap smears, check-ups, skin checks, Keep Well visits.

Do you provide consent to be contacted with health reminders relevant to you?

☐ Yes ☐ No

Please turn over for page 2

DUBBO FAMILY DOCTORS

New Patient Information Form – please complete all 3 pages

Cultural Identity:

Australia is a genuinely multicultural society. To help us to tailor appropriate care, and to assist with health initiatives that may be available to you, what is your cultural background?

☐ Non- Aboriginal Australian
☐ Aboriginal / Torres Strait Islander Australian
☐ Other – Please specify e.g. Italian, Chinese,_____

If you are Aboriginal or a Torres Strait Islander, are you registered for CTG - Closing the Gap

☐ Yes ☐ No

Your Health History:

Do you have or have you had a history of? (tick the relevant boxes)

Operations		Strokes or mini-strokes	
Heart attacks or angina		Depression, anxiety, other mental illness	
High blood pressure		Arthritis	
Asthma		Osteoporosis	
Emphysema, chronic bronchitis, or COPD		Skin cancers	
Diabetes		Other	

Allergies:

Do you have any allergies?

☐ Yes (If yes, please list below) ☐ No

_____

_____

Immunisations

Have you had the following immunisations?

Tetanus booster date_____ ☐ Don't Know ☐ Haven't had one
Whooping cough (pertussis) date_____ ☐ Don't Know ☐ Haven't had one
Hepatitis B date_____ ☐ Don't Know ☐ Haven't had one
Hepatitis A date_____ ☐ Don't Know ☐ Haven't had one
Influenza date_____ ☐ Don't Know ☐ Haven't had one
Pneumococcal date_____ ☐ Don't Know ☐ Haven't had one
HPV (Gardasil / Cervarix) date_____ ☐ Don't Know ☐ Haven't had one

Children's immunisations - if completing this form for a child, are their immunisations up to date?

☐ Yes ☐ No

Current Medications:

What medications do you currently take? (Please include all medications including contraceptive pill, over the counter medications, vitamins and minerals):

_____

_____

_____

New Patient Information Form – please complete all 3 pages

Family History:

Have any members of your family had? (tick the relevant boxes)

Heart disease		Mental illness	
Asthma		Cancer	
Diabetes		Other health conditions	

Social history:

Occupation _____

☐ Smoking (tobacco): _____ per day / week (circle the one applicable)

☐ Ceased Smoking – date: _____

☐ Alcohol: _____ drinks per day / week / month (circle the one applicable)

☐ Drug use: _____ (type and how often)

Sun protection:

How often do you use the following to protect yourself from the sun when outdoors?

	Always	Often	Sometimes	Rarely	Never
Protective clothing	☐	☐	☐	☐	☐
Sunscreen	☐	☐	☐	☐	☐

When was your last full skin check?

Females:

When did you last have:

An overall check up	Date _____	☐ not sure	☐ never
Pap smear	Date_____	☐ not sure	☐ never
Mammogram	Date_____	☐ not sure	☐ never

Males:

When did you last have:

An overall check up	Date _____	☐ not sure	☐ never

Research and Quality Programs:

Our practice undertakes research, professional development, and quality assurance and improvement activities to improve patient care. Confidentiality and privacy will be maintained.

Do you consent to your health record being reviewed as part of the quality improvement activities at our practice?

☐ Yes ☐ No

Third Party Consent:

If you wish to authorise a third party to access information on your behalf please give their details:

Name _____ Relationship to you _____

Phone contact number _____

Signature of patient or guardian_____ Date _____

DUBBO FAMILY DOCTORS