BLACKWOOD CLINIC

New Patient Form

Patient Name: ….....

Date of Birth: ….....Occupation: ….....

Address: …..... Postcode: ….....

***Do you identify yourself as Aboriginal or Torres Strait Islander Yes/ No**
***What is your ethnicity/cultural background? e.g. Australian/Greek/Italian**

Please identify: .....

Telephone:(Home): ..... Mobile):.....
***Do you consent to SMS reminders : YES/NO**

Email Address: ….....

Medicare Number: _ _ _ _ _ _ _ _ _ _ _ Ref No (number in front of name): ….....

Expiry Date: …..... /..... **OR** DVA Number: …..... Expiry Date: …..... /.....

Pension / Health Care / Commonwealth Seniors Card (please circle)
Centre link Concession Card Number: _ _ _ _ _ _ _ _ _ _ Expiry Date: ____ /___ / ___

Parent's Name (if patient under 16 years): **….....** ***Parent's DOB:*** **….....**
Parent's Medicare Number: **_ _ _ _ _ _ _ _ _ _ _** ***Ref No:*** **____**

Emergency Information and Next of Kin			
The person(s) you wish to be contacted in the case of an emergency: Please provide **full name** & at least one contact number			
			Relationship (Opt)
			Relationship (Opt)

I authorise The Blackwood Clinic to access my/my child's medical file and personal details, for doctors and practice staff to converse with other doctors, specialists and their staff and other healthcare providers who are directly involved with my care, regarding my health and medical wellbeing. Our practice uses a reminder system in conjunction with state and national registers to improve the quality of your health care. This reminder system generates reminders to patients for procedures such as vaccinations, pap smears and other health reviews.

□ I consent to being contacted with reminders as a part of the quality improvement activities of this practice.
□ I accept that I am responsible for the payment of all fees generated on my behalf by this Practice.

We require 4 hours notice for cancellation of appointments, where possible, otherwise a cancellation fee will apply.

Signature of Patient / Guardian……Date……..

BLACKWOOD CLINIC

Medical History Form

Dear Patient,

To assist your Doctor to best service your health needs please complete the following information and hand this form to your Doctor.

Name: …..... **DOB:** …..

Height: ….. **Weight:** ..... **Waist Circumference:** …..... **Elite Athlete: Yes/ No**
(if unknown please see the nurse or doctor for assistance)

Retired: Yes/No **Occupation:** …..... **Carer: Yes/ No**

Smoker: ☐**Current** **Year Commenced:** …..... **Amount/Day:** …..
☐**Former** **Year Commenced:** …..... **Year Ceased:** …..... **Amount/Day:** .....
☐**Never**

Alcohol: ☐**Yes** **How many days/ week:** ..... **Glasses/day:** …..... ☐ **Non Drinker**

If Yes Please Circle: Beer Wine Spirits

Current Medications (inc over the counter/herbal): …..

…..

…..

Previous Medical Conditions (inc year diagnosed): …..

…..

Previous Operations (inc year of surgery): …..

…..

Medical Allergies and/or Anaesthetic Allergies: **Nil Known** ☐

Drug	Reaction	Date

Family History: *(Eg. Cancer, High Blood pressure, Diabetes, Asthma, Stroke, Colon Cancer, Depression or Breast Cancer)*

☐ **Nil Significant History** ☐**Unknown**

Father: …..

Mother: …..

Siblings: …..

Children: …..