Power Medical Centre
90 West Street
Busselton WA 6280
Phone: 9752 9555
Fax: 9752 9556
ABN : 79 604 641 625

NEW PATIENT FORM

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

Personal Details:			
Title	Mr Mrs Ms Miss Dr Other:		
Surname		**Date of Birth**	
First Name		**Middle Name**	
Street Address		**Preferred Name**	
Suburb		**Post Code**	
Postal Address:			
Phone / Home :	**Work :**	**Mobile:**	
Email Address:		**Consent to SMS Reminder?** Yes No	
Preferred Contact Method (Circle)**:** Home phone Work phone Mobile phone Email SMS			
Occupation:		**Past Occupation:**	
How did you hear about us? (Circle)	Google Health Engine HotDoc Facebook Friend/Family Mail Other, Please indicate _____		

Health Care Details:			
Medicare Number	☐☐☐☐☐☐☐☐☐☐	**Ref Number:**	**Expiry:**
DVA Gold / White (Please Circle)		**Expiry Date:**	
Pension Number		**Expiry Date:**	
Concession Healthcare Card		**Expiry Date:**	

Emergency Contact Details:		
Next of Kin (Full Name):	**Contact Number:**	**Relationship:**
Emergency Contact (Full Name):	**Contact Number:**	**Relationship:**

Australia is a genuinely multicultural society. To tailor appropriate care, encourage understanding and appreciation between people from different nationalities and backgrounds please complete this section

Country of Birth:	**Ethnicity:**
Do you require a Translator? Yes No	
To assist with health initiatives – are you Aboriginal or Torres Strait Islander? (please Circle) Aboriginal Torres Strait Islander Aboriginal & Torres Strait Islander No	

CANCELLATION POLICY

Please telephone the surgery to cancel at least 4 hours prior to your appointment. This will allow the doctors to reschedule in another patient who needs to be consulted; failing to do so will result in **a fee of $40.00 per 10 minute booking** time allocated. Payment of such fee will be required in full prior to any future appointment booking.

DID NOT ATTEND APPOINTMENTS – Any appointment that is not cancelled and you do not attend or 'no-show' for your appointment, will be dealt with as per our cancellation policy above.

Signature_____ Date_____/_____/_____

Please turn over

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Surname: _____ First Name: _____ Date of Birth ___/____/_____

Current medications (including over the counter medication, vitamins, minerals and/or health supplements):

_____

_____

_____

Do you have any allergies or are you sensitive to drugs or dressings? ☐ Yes (Please specify below) ☐ No

_____

What is the reaction you have? _____

Your Health History: Do you have or have a history of? (please tick)			
	Operations (give details):		Hypertension
	Asthma		Chronic Illness (give details):
	Diabetes		Other (give details):
Do you know your blood group? Yes No		**Blood Group:**	
Do you live with a carer? Yes No		**Name & Contact:**	

If this information is for your child please provide a copy of your child's immunisation history to the receptionist.

Family History: Have any members of your family had? (please tick) Please specify which family relation e.g. mother father, grandmother etc.			
	Diabetes		Mental Illness (give details)
	Asthma		Cancer (give details)
	Heart Disease		Other (give details)

NOTE: This section may not be applicable for some patients.

Social History:	
Do you smoke? Yes: _____/day No	Past smoking history: Nil Light Moderate Heavy Which year did you stop smoking? _____
Do you drink alcohol? Yes: _____/day No	Past drinking history: Nil Light Moderate Heavy Which year did you stop drinking? _____
Females: When did you last have? Pap Smear Date: _____ Not Sure/Never Breast Check Date: _____ Not Sure/Never	**For those 65 years and older: When was the last time you were immunised?** Influenza Date: _____ Not Sure/Never Pneumococcal Date: _____ Not Sure/Never

At **Power Medical Centre** we strive to provide high quality care, appropriate to meet our client's health care requirements.

By becoming a patient of Power 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 **Power 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 through my preferred method of contact.

Signature_____ Date_____/_____/_____

Printed Name _____ (If the patient is under 16 years the parent/guardian is to sign)