New Patient Form

(Please complete and return to reception)

Title Dr Mr Miss Ms Mrs (Please Circle)

First Name: ______________________ Surname: ______________________

Address: ____

Suburb: ______________________ Postcode: ____________

Phone (h) ____________ (m) ____________ Date of Birth: ____________

Occupation (helps us to identify industry specific medical concerns) ____________________

Email Address: ____

Medicare Card Number ______________________ Expiry Date: ____________

Individual Reference Number (number next to your name) ____________________

Veterans Affairs Card Number: ______________________ Expiry Date: ____________

Concession Card Number: ____________________

Concession Card Expiry Date: ____________________

☐ Health Care Card ☐ Pensioner Card

Are you of Aboriginal or Torres Strait Islander Ethnicity: No Yes Ethnicity: ____________

Next of Kin contact name: ____

Next of Kin contact number: ____

Relationship to you: ______________ Is this person also your emergency contact ☐ Yes ☐ No

Emergency contact name: ____

Emergency contact number: ______________________ Relationship to you: ____________

Do you have any Allergies?

☐ None Known ☐ Penicillin ☐ Latex ☐ Keflex ☐ Codeine ☐ Adhesives/Bandages

Other ____

Severity of reaction Mild ☐ Moderate ☐ Severe ☐

Do you smoke: ☐ No ☐ Yes Ex-Smoker (how long) ____________________

NHS Australia Medical Centre Blue Haven
15 Roper Road BLUE HAVEN NSW 2262
p 02 4399 1755 · f 02 4399 1855 · admin@nhsbluehaven.com

(Please Turn Over)

Patient History

(Please complete and return to reception)

Family History (Please circle)

Is your Mother alive? Yes No If No, what was her Cause of Death: ____________________

Age of Death: ______________

Is your Father Alive? Yes No If No, what was his Cause of Death: ____________________

Age of Death: ______________

Unknown (eg Adopted) Yes

Significant Family history (please tick if relevant)

	Diabetes	Breast or Colon Cancer	Hypertension	Heart Disease	Stroke	Depression
Mother						
Father						

Other significant medical information: ____

____

Social/Lifestyle History (please circle)

Marital Status: Single Married De facto Divorced Separated Widow

Accommodation: Own Home Rent Nursing home Homeless Other private home

Do you live with: Alone Relative Friend Spouse Share house

Do you have a carer? Yes No If Yes, Carer's name: ________________________

Current Alcohol Intake: Non drinker No. drinks per day ________________________

Past Alcohol Intake (Please Circle) Nil Occasional Moderate Heavy

Privacy Disclaimer (a copy of our privacy policy is available upon request)

I provide my consent for NHS Australia Medical Centre Blue Haven to collect, use and disclose my personal information as reasonably required for medical purposes. I understand that I am not obliged to provide any information requested of me but that my failure to do so might compromise the quality of the health care and treatment given to me. I understand that I am entitled to access my own health care records except where access might be legitimately withheld. I understand that I will be given an explanation in these circumstances. I understand that I may withdraw my consent to use and disclosure of my personal information (except when legal obligations must be met).

Signature: ______________________________ Date: ________________