Ladywood Clinic

New Patient Form

Title:	*Mr / Mrs / Ms / Miss / Mast / Dr* **OR** *Other* _______		
Surname:		**First Name:**	
Middle Name:		**Preferred Name:**	
DOB:		**Occupation:**	
Residential Address:	*Number/ Street:* ________________________________ *Suburb:* ________________________ *Post Code:*__________		
Postal Address:	***Please tick if same as above*** ☐		
Home Phone:	( )	**Mobile:**	
Work Phone:	( )	**Email:**	

Do you identify as:	*Aboriginal/ Torres Strait Islander/ Both ATSI*		*Yes / No*
If YES: *Are you registered for the CTG PBS Co-Payment:* *YES*			*NO* *Would Like To*
Ethnicity:		**Language Spoken :**	*(if not English)*
Will an interpreter be required?			*Yes / No*
Do you require the services of the NRS for hearing & speech impaired?			*Yes / No*

Medicare No:	☐☐☐☐- ☐☐☐☐☐ -☐ *Ref No* ☐	**Exp Date:**	__ / ____	
Concession Card:	☐☐☐☐☐☐☐☐☐☐ ***Pension or Health Care Card – please circle***	**Expires:**	__/__/____	
DVA:	☐☐☐☐☐☐☐☐☐☐ ***Gold / White*** *(circle)*	**Expires:**	__/____	
Private Health Fund:		**Member No:**	_ _ _ _ _ _ _ _ _ _ _ _	

Next of Kin:	*Full Name:*	
	Relationship to Patient:	
	Address:	
	Phone:	Mobile - Home -
Emergency Contact: Please tick if same as above ☐	*Full Name:*	
	Relationship to Patient:	
	Address:	
	Phone:	*Mobile - Home -*

Please list any allergies: food, medications, dressings etc: ***(Please also state reaction experienced & severity)***
Please tick if Nil Known ☐

Please list any current medications: including over the counter medications and vitamins:

Please list any past and current medical conditions / operations / accidents / disabilities:

Please list any significant family medical history: *i.e. high blood pressure, heart disease, cancer, diabetes etc.*

Smoking Status:	*Current Smoker*	*Yes / No*	*Year Started: __________*	*Amount: __________*
	Ex-Smoker	*Yes / No*	*Year Started: __________*	*Year Stopped: __________*
Alcohol Intake:	*No. of Standard Drinks:*		*Per Day – __________*	*Per Week – __________*

Please advise if any of the following Immunisations / Health Checks have been received in the past:		
Tetanus	*Yes / No / Unsure*	*approx. date: ___________*
Flu Vaccine	*Yes / No / Unsure*	*approx. date: ___________*
CHILD: are their immunisations up to date?	*Yes / No / Unsure*	*approx. date: ___________*
FEMALE: Breast Check	*Yes / No / Unsure*	*approx. date: ___________*
FEMALE: Pap Smear	*Yes / No / Unsure*	*approx. date: ___________*
MALE: Overall Check up	*Yes / No / Unsure*	*approx. date: ___________*
Reminder Systems: ***Do you consent to SMS contact/reminders from the surgery?***	***YES***	***NO***

Payment of Accounts:

Please note, our practice utilises TYRO for claiming and payments of services. Unless arranged prior to your appointment, this requires the full consult fee (including any non-reimbursable gap payment), to be paid on the day. All Pension, Concession Health Care Card holders, DVA Card holders and children under 17 years will be Bulk Billed.

I ___________________________________ *(self / parent / guardian), have read and accept the terms of the above*
(PRINT NAME)

Signed: ________________________________ *Date:* __________

Results of Pathology and Radiology Tests

It is the policy of the practice to only provide results to yourself or any relevant practitioners involved in your treatment for specific reasons (e.g. referred Specialists, Allied Health, compensation providers etc.). If you wish to authorise any other representative on your behalf, please note this below:

Name: __________________________________ Relationship to You: ___________________________________

Signed: __________________________________ Print:_______________________________ Date: __________

Should these details change at any time, please notify the practice as soon as possible.

Please, also, be aware that although we offer a recall service for some pathology, it is still the responsibility of the patient to contact us regarding obtaining results.

Privacy and Security of Health Records

On occasion details regarding your health may be shared with relevant third parties pertinent to your healthcare needs; all necessary measures will be met to ensure your privacy and confidentiality. The National Privacy Principles in the Privacy Act sets out how this Practice should collect, use, keep secure and disclose personal information. A copy of our Privacy Policy is available for all patients which outlines the terms in which your health information is managed and utilised.

I consent to the collection and use of my information by this practice:

Signed: __________________________________ Print:_______________________________ Date: __________

How did you hear about us?

- ☐ *Mail Drop Brochure*
- ☐ *Messenger Ad*
- ☐ *Family/Friends*
- ☐ *School Calendar*
- ☐ *Previous Patient of Dr*
- ☐ *Other* ____________________________