Forrest Road MEDICAL CENTRE

2/65 Forrest Rd, Padbury WA 6065
Ph:9402 1922
Fax:94021597

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

NEW PATIENT DETAILS - Please print and give as much detail as possible to assist us to provide quality care.

Full name: Mr Mrs Ms Miss Dr Surname: _____ First Name: _____ Middle Name: _____

Date of Birth ___/____/_____ Ethnicity: Aboriginal TSI ATSI Other _____

Medicare or Vet Affairs No._____ Ref no _____ (next to name) Exp_____

Pension/Healthcare Card No._____ Exp_____

Do you have private health care fund. Yes No Which Fund _____ Fund Number _____

Address: _____

Suburb: _____ Postcode: _____

Phone: _____ Mobile: _____ Business: _____contact at work yes/no

Email Address: _____

Occupation: _____ Country of Birth: _____
Preferred Method of Contact (please circle): Mobile SMS Email Home Phone Work Phone

Consent to SMS (please circle): Yes No

Next of Kin _____ Relationship _____Phone _____

Emergency Contact Person_____ Relationship: _____

Contact Phone No: _____ Mobile Phone No: _____ Business: _____

At Forrest Road Medical Centre we strive to provide high quality care, appropriate to meet our clients health care requirements.

By becoming a patient of Forrest Road 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 Forrest Road 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 to the above address.

Signature_____ Date_____/_____/_____

Printed Name _____

PLEASE TAKE THIS SECTION TO DOCTOR

Full name: Mr Mrs Ms Miss Dr Surname: _____ First Name: _____ Middle Name: _____

Current Medications and Doses: _____

_____

Please list any known allergies and your reactions or list nil known if none: _____

_____

Please list any operations or previous illnesses: _____

_____

SOCIAL HISTORY: Please circle the most appropriate answer fill out all other areas

Marital Status: Single Married De-facto Divorced Widowed Separated

Alcohol Consumption: Do you drink alcohol? Yes No If yes how much _____

Smoking: Do you smoke? Yes No If yes how many per day ? _____

FAMILY HISTORY: Please circle the most appropriate answer fill out all other areas
Family History: No significant family history Other – see list below

Diabetes Kidney Disease Asthma High Blood Pressure Heart Problems
Breast Cancer Colon Cancer Stroke Depression Epilepsy Other Cancer

How did you find out about our surgery?

Word of Mouth White Pages Yellow pages Relatives Drive/walk past
Leaflets/flyers Pharmacy Google Others