# New Patient Form

**Title:** Mr. Mrs. Ms. Miss Mast Other: ……

**First Name:** …… **Middle Name/s:** ……

**Family Name:** …… **Birth Sex:** ……

**Date of Birth:** …… **Gender Identity/Pronouns:** ……

**Ethnicity:** …… **Country of Birth:** ……

**Preferred Language:** …… **Occupation:** ……

**Address:** ……

**Suburb:** …… **Postcode:** ……

**Phone Number:** …… **Do you consent to SMS reminders:** YES / NO

**Email Address:** ……

**Medicare Card Number:** …… **IRN:** …… **Expiry Date:** ……

**Pension/HCC Type:** …… **Pension/HCC Number:** …… **Expiry:** ……

**DVA Number (if applicable):** …… **Card Type:** ……

**Emergency Contact Information** (Please provide **full name** & at least one contact number)

Emergency Contact: …… Phone: …… Relationship: ……

Next of Kin: …… Phone: …… Relationship: ……

***If patient under 16 years:** Parent's Name**:** …… DOB: ……

**Parent's Medicare Card Number:** …… **IRN:** …… **Expiry Date:** ……

I authorise The Blackwood Clinic to access my/my child's medical file and personal details and 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 including reminders for Vaccinations, Cervical Screenings 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.
□ I understand that **4 hours notice** is required for the cancellation of appointments where possible otherwise a cancellation fee may apply.

**Signature of Patient / Guardian**…… **Date**……

# Medical History Form

Dear Patient,
To assist your GP to best service your health needs please complete the following information and hand this form to your doctor (leave questions blank if unable to answer)

**Name:** ..... **DOB:** .....

**Height:** ..... **Weight:** ..... **Waist Circumference:** .....

**Retired:** YES / NO **Do you have a Carer:** YES / NO

**Smoker:** Current / Former / Never: **Commenced:** ..... **Amount Per Day:** .....

**Year Ceased:** .....

**Alcohol:** YES / NO **Glasses per day:** .....

**Current Medications (please include over the counter/herbal):**
.....
.....
.....

**Current/Previous Medical Conditions:**
.....
.....

**Previous Operations (year of surgery):**
.....
.....

**Medical Allergies and/or Anaesthetic Allergies:**
.....

**Family History:** *(E.g. Cancer, High Blood pressure, Diabetes, Asthma, Stroke, Colon Cancer, Depression or Breast Cancer)*
.....
.....
**Mother:**
.....
**Father:**
.....
**Siblings:**
.....
**Children:**
.....