HIGHLAND MEDICAL
Unit 4, 210 Wanneroo Road
Madeley WA 6065

NEW PATIENT DETAILS

This information is private and confidential and is for use in your clinical file only. Please provide as much detail as possible to assist us to provide quality care

Please Circle: Mr Mrs Ms Miss Mast Dr Mx

Surname: _____ **First Name:** _____ **Middle:** _____

Date of Birth: _____/_____/_____ **Preferred Name:** _____

Birth Sex: Male / Female / Unknown / Other **If Other:** _____

Gender Identity: _____ **Pronouns:** _____

Family Ethnicity: Aboriginal/TSI; Other _____ **Country of birth:** _____

Address: _____

Suburb: _____ **Postcode:** _____

Phone: _____ **Mobile:** _____ **Do you consent to SMS contact?** YES / NO

Email: _____

Medicare Card or DVA No. _____ **Ref no** _____ **(Next to Name) Exp:**_____

Pension Concession / Healthcare Card:_____ **Exp:**_____

Next of Kin: _____ **Relationship:** _____ **Phone:** _____

Emergency Contact: _____ **Relationship:** _____ **Phone:** _____

By becoming a patient of Highland Medical Centre and signing this new patient form I agree/consent to the following:

- I consent to the use of my personal health information by Highland 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 directly or indirectly involved in my personal health care or medical treatment
- I consent to receive follow up reminders and recalls to be sent to the above address. As part of preventative health services offered by this practice, we send out follow up reminders and recalls when routine investigations are due

I understand that if I make an appointment and do not arrive or cancel the appointment without 1-hour minimum notice, I will receive a missed appointment fee to be paid prior to further bookings

Printed Name:_____ **Date**_____/_____/_____

Signature: _____

How did you find out about our surgery?

Word of Mouth Drive/Walk past Hot Doc Social Media Family

Online e g Google/Highland Medical Website Followed Dr Other-Specify_____

PLEASE TAKE THIS SECTION TO THE DOCTOR

Please Circle: Mr Mrs Ms Miss Mast Dr Mx Date of Birth _____/_____/_____

Surname: _____ First Name: _____ Middle: _____

Weight: _____kg Height: _____cm Waist Circumference: _____cm

ALLERGIES: Please list any known allergies: (Please Circle)

_____ Reactions: _____ Mild / Moderate / Severe

_____ Reactions: _____ Mild / Moderate / Severe

_____ Reactions: _____ Mild / Moderate / Severe

MEDICATIONS: Your Current Medications and Doses: _____

_____

_____

Please list any operations or previous illnesses: _____

_____

_____

FAMILY HISTORY: **Unknown (eg Adopted)** ☐

Mother: Still alive: Yes / No If no, Age at Death: _____ Cause of death: _____

Diabetes Asthma High Blood Pressure Heart Disease Stroke Depression Cancer – please state _____

Father: Still alive: Yes / No If no, Age at Death: _____ Cause of death: _____

Diabetes Asthma High Blood Pressure Heart Disease Stroke Depression Cancer – please state _____

Other immediate family significant illness: _____ Relationship: _____

SOCIAL HISTORY:

Current Alcohol Intake: How many days per week? _____ How many per day? _____ Non-Drinker ☐

Past Alcohol History: Nil / Occasional / Moderate / Heavy

Do you smoke / vape? Yes / No If yes, how many per day ? _____

Past Smoking History: Nil / Light / Moderate / Heavy Which year did you stop smoking? _____

CERVICAL SCREENING: Date of last Pap Smear / Cervical Screening: _____

Where performed _____ Result: _____

At Highland Medical Centre we strive to provide high quality care, appropriate to meet our client's health care requirements Your feedback is important to us Please feel free to fill in a Suggestions form at the front counter