medicross medical

NEW PATIENT INFORMATION FORM

STRICTLY CONFIDENTIAL

PERSONAL DETAILS

TITLE	MR/MRS/MISS/DR		
FAMILY NAME			
GIVEN NAMES			
PREFERRED NAME			
DATE OF BIRTH	DD/MM/YYYY	GENDER	

CONTACT DETAILS

ADDRESS 1			
ADDRESS 2			
CITY / SUBURB			
STATE		POSTCODE	
HOME NO.		WORK NO.	
MOBILE NO.		CONSENT TO RECIEVE SMS	☐ YES ☐ NO PLEASE TICK ONE
EMAIL			

CULTURAL BACKGROUND

Are you of Aboriginal / Torres Strait Islander origin? (Mark with X)

NO	☐ NO
ABORIGINAL	☐ YES
TORRES STRAIT ISLANDER	☐ YES
BOTH ABORIGINAL AND TORRES STRAIT ISLANDER	☐ YES

What is your ethnicity? (Australian / Indian / Chinese / Greek, etc.)

Where is your Country of Birth?

HOW DID YOU HEAR ABOUT MEDICROSS?

GOOGLE/SIGNAGE/FRIEND ETC

INSURANCE DETAILS

MEDICARE NO.		REF NO.		EXPIRY DATE	DD/MM/YYYY
PENSION CARD NO.		EXPIRY DATE:	DD/MM/YYYY		
HEALTHCARE CARD NO.		EXPIRY DATE:			
DVA NO.					

NEXT OF KIN

NAME		SURNAME	
RELATIONSHIP		CONTACT NO.	

EMERGENCY CONTACT

☐ Tick here if same as Next of Kin

NAME		SURNAME	
RELATIONSHIP		CONTACT NO.	

FAMILY (CHILDREN UNDER 16 ONLY)

						GENDER
NAME		MEDICARE REF NO.		D.O.B.	DD/MM/YYYY	GENDER
NAME		MEDICARE REF NO.		D.O.B.	DD/MM/YYYY	GENDER
NAME		MEDICARE REF NO.		D.O.B.	DD/MM/YYYY	GENDER

BOOK YOUR NEXT APPOINTMENT USING THE MEDICROSS APP OR BOOK ONLINE AT WWW.MEDICROSS.COM.AU

PLEASE TURN OVER

MEDICAL INFORMATION FOR

NAME	
SURNAME	
ALLERGIES (PLEASE LIST ALL KNOWN ALLERGIES)	

HEIGHT	_____ CMS
WEIGHT	_____ KGS

SOCIAL HISTORY

TOBACCO (PLEASE SELECT ONE)	☐ SMOKER _____ PER ☐ DAY / ☐ WEEK ☐ EX-SMOKER DATE CEASED: _____ ☐ NEVER
ALCOHOL	☐ NON-DRINKER _____ UNITS PER ☐ DAY / ☐ WEEK / ☐ MONTH
DRUG USE	_____ (TYPE / FREQUENCY)

FAMILY HISTORY

Have any of your family members had any of the following:

☐ ASTHMA ☐ DIABETES
☐ CANCER ☐ HEART DISEASE
☐ MENTAL ILLNESS
☐ OTHER _____

IMMUNISATIONS Have you had the following immunisations?

☐ TETANUS BOOSTER	DATE: _____	☐ NOT SURE	☐ NEVER
☐ HEPATITIS B	DATE: _____	☐ NOT SURE	☐ NEVER
☐ HEPATITIS A	DATE: _____	☐ NOT SURE	☐ NEVER
☐ INFLUENZA	DATE: _____	☐ NOT SURE	☐ NEVER
☐ PNEUMOCOCCAL	DATE: _____	☐ NOT SURE	☐ NEVER

CHILDREN'S IMMUNISATIONS If completing this form for a child, are their immunisation up to date?

☐ YES ☐ NO

65 YEARS AND OLDER When was the last time you were immunised?

☐ INFLUENZA	DATE: _____	☐ NOT SURE	☐ NEVER
☐ PNEUMOCOCCAL	DATE: _____	☐ NOT SURE	☐ NEVER

SUN PROTECTION How often do you use the following to protect yourself from the sun when outdoors?

PROTECTIVE CLOTHING	☐ ALWAYS	☐ OFTEN	☐ SOMETIMES	☐ RARELY	☐ NEVER
SUNSCREEN CREAMS	☐ ALWAYS	☐ OFTEN	☐ SOMETIMES	☐ RARELY	☐ NEVER

FEMALES When did you last have:

PAP SMEAR	DATE: _____	☐ NOT SURE	☐ NEVER
BREAST CHECK	DATE: _____	☐ NOT SURE	☐ NEVER
OVERALL CHECK	DATE: _____	☐ NOT SURE	☐ NEVER

MALES When did you last have:

AN OVERALL CHECK-UP	DATE: _____	☐ NOT SURE	☐ NEVER

MYHEALTH RECORDS

I consent to upload my medical record to MyHealth ☐ YES ☐ NO _____
SIGNATURE

medicross medical

PRACTICE POLICY AGREEMENT

BY BECOMING A PATIENT OF MEDICROSS AND SIGNING BELOW I HAVE READ AND AGREE TO THE FOLLOWING:

- Standard appointments are **10 minutes** and generally cover **one health concern**. If you have more than one health concern, a complex health issue or require a longer appointment for any other reason please **notify reception at the time of booking**. A separate appointment must be made per person/family member. This will assist the doctors with running on time.
- An **appointment** must be made with a **doctor** to **obtain results**, **repeat prescriptions** or **referrals**. **Results will not be given over the phone.**
- Please ensure **mobile phones** are **turned off** during the consultation.
- Patients that **fail to attend an appointment** without notice may incur a **$70 fee** and will be unable to attend the practice until the account is paid.
- Patients who are **late** to their appointment may have to **wait** until other patients who arrived on time are seen or in some cases **reschedule** the appointment altogether; this is at the discretion of the doctor.
- Doctors at this practice **do not prescribe schedule 8 drugs** and have a **no-tolerance policy to doctor shoppers and drug seekers**. Doctors have the right to refuse the request for prescription drugs.
- This practice has a **no-tolerance policy for aggressive or abusive behaviour**. Patients who are **physically or verbally aggressive to staff** will be **banned** from the practice at the discretion of the doctor or practice manager.
- **It is at the discretion of the doctor and practice staff to provide personal health information to parents/guardians of patients under the age of 16.** All patients 16 and over are considered adults and information will not be disclosed to parents/guardians/friends/spouse without permission from the patient. If you would like to nominate a person to have access to your health information and communicate with us on your behalf please ask reception for a Third Party Access Consent form.
- The Practice has a **Privacy Policy** in place which is available on request. This policy will state how we will deal with all personal and sensitive information which includes health information in a confidential and professional manner.
- Our practice uses **reminder systems** to help you maintain your health. The practice may send **reminders** by **post**, **email** and/or **telephone** for procedures such as Vaccinations, Pap Smears and other Health Services. Our practice also sends information to the Australian Childhood Immunisation Register, Pap Smear Register and Primary Health Care Network (deidentified information).
- I understand - by indicating by signing below - that the Practice is authorised on my behalf to use my relevant personal health information and I am free to withdraw my consent at any one time by verbal or written notification.

I HEREBY CONSENT TO THIS POLICY AGREEMENT

NAME OF PATIENT (PLEASE PRINT)	
SIGNATURE OF PATIENT	
PRINT NAME & SIGNATURE OF PARENT/GUARDIAN (IF UNDER 16)	

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