NEW PATIENT INFORMATION FORM

STRICTLY CONFIDENTIAL

TO ASSIST US IN PROVIDING QUALITY HEALTH CARE PLEASE COMPLETE ALL SECTIONS OF THIS FORM AS ACCURATELY AS POSSIBLE.

Please note: We are a MIXED BILLING PRACTICE - patients between the age of 12 - 74 years old will incur a fee for your consultation. Discount fees are available for patients with a current concession card. Procedures and other consultations that are not covered by Medicare may also incur a private fee (reception/GP will quote you a price before your appointment or procedure).

Payment is required at the time of your appointment, please see reception after your consultation to process your payment and claim your rebate from Medicare, using Medicare Easy claim.

Make an appointment by calling 07 3341 2791; online at http://medicross.com.au/rochedale/

OR by scanning the QR code: SCAN ME

PERSONAL DETAILS:

FIRST NAME:			**PREFERRED NAME:**
SURNAME:			**OCCUPATION:**
D.O.B:	/ /	**BIRTH SEX:**	**GENDER IDENTITY:**
ETHNICITY:			**RELIGON:**
CULTURE:	ARE YOU ABORIGINAL OR TORRES STRAIGHT ISLANDER? YES ◯ NO ◯ BOTH ◯		

CONTACT DETAILS:

ADDRESS:			
SUBURB:		**POST CODE:**	
MOBILE:		**HOME PHONE:**	
EMAIL:			
CONSENT TO RECEIVE SMS REMINDERS (including appointment reminders):	YES ◯ NO ◯	CONSENT TO RECEIVE EMAIL CORRESPONDENCE: **Please note that email is not secure or encrypted.**	YES ◯ NO ◯

INSURANCE DETAILS:

MEDICARE NO:		IRN:		EXPIRY DATE:	/ / 20__
PENSION CARD NO:				EXPIRY DATE:	/ / 20__
HEALTHCARE CARD NO: (NOT private health insurance)				EXPIRY DATE:	/ / 20___

NEXT OF KIN:

FULL NAME:		
CONTACT NUMBER:		RELATIONSHIP TO YOU:

EMERGENCY CONTACT: **PLEASE TICK IF SAME AS NEXT OF KIN** ◯

FULL NAME:		
CONTACT NUMBER:		RELATIONSHIP TO YOU:

ALLERGIES:

WHAT ARE YOU ALLERGIC TO?	REACTION:	SEVERITY:

FAMILY HISTORY – HAVE ANY OF YOUR FAMILY MEMBERS HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS?

CONDITION:	YES	NO	TYPE	RELATIONSHIP TO YOU:
ASTHMA				
DIABETES				
HEART DISEASE				
MENTAL ILLNESS				
CANCER				

	YES	NO	AGE OF DEATH	CAUSE OF DEATH
IS YOUR MOTHER ALIVE?				
IS YOUR FATHER ALIVE?				

SOCIAL HISTORY:

MARITAL STATUS ***(please circle one)*****:** SINGLE / MARRIED / DEFACTO / SEPARATED / DIVORCED / WIDOWED		
DO YOU HAVE AN ADVANCED HEALTH CARE DIRECTIVE? *(Legal document stating your medical & health choices in the event you are incapable)*	YES ◯ NO ◯	
DO YOU HAVE ENDURING POWER OF ATTORNEY? *(Legal document appointing someone to make decisions for you in the event you are incapable)*	YES ◯ NO ◯	
WHO DO YOU LIVE WITH? ***(please circle one)*****:** SPOUSE / PARTNER / FAMILY / FRIEND / ALONE		
DO YOU HAVE A CARER?	YES ◯ NO ◯	
IF YES - CARER'S NAME:		CONTACT NUMBER:
ARE YOU A CARER?	YES ◯ NO ◯	

DO YOU:	IF YES – HOW MANY PER DAY?	IF NO -– YEAR STOPPED?
SMOKE TOBACCO:		
DRINK ALCOHOL:		
TAKE RECREATIONAL DRUGS:	TYPE?	FREQUENCY:

MYHEALTH RECORD - I CONSENT TO UPLOAD MY MEDICAL RECORD TO MYHEALTH? YES ◯ NO ◯

SIGNATURE: _____ DATE: ____/____/_____

HOW DID YOU HEAR ABOUT MEDICROSS? _____