Patient Name: ………………………………………………………..

NEW PATIENT INFORMATION FORM

Title ……………. First Name ……………………………… Surname ………………………………… Preferred name ………………………………

D.O.B …………………… Occupation …………………………………………

Residential Address ……………………………………………………………
…………………………………………………………………………………………

Mobile …………………………… Home ………………… Work ……………
For your privacy, please circle any numbers NOT to be used for messages
Can we leave messages for you identifying the practice as the caller? Yes ☐ No ☐

Email …………………………………………………………………………..
By providing my email above, I consent to use email and acknowledge that email is not a secure form of communication

Next of Kin Name ……………………………………………………….

Relationship …………………………. Phone ……………………….

If patient under 18 years, person responsible for account:

Name ………………………………. Phone # ……………………….
Address ……………………………………………………………………..
……………………………………………………………………………………..

Are there any custody agreements or court orders in place? Yes ☐ No ☐

Who referred you to this practice (Doctor or Dentist)?

Name …………………………………………….. Referral Date ……………..

Address ………………………………………………………………………….
Phone ……………………………….

Who is your General Medical Practitioner?

Dr ……………………………………………. Phone …………………..

Practice Name & Address …………………………………………..
……………………………………………………………………………………..

Medicare Number …………………………………………………..
Expiry Date ………………………. Reference Number ………

DVA number …………………………… Reference Number ………
Expiry Date ………………………... Card Type: White ☐ Gold ☐

Information disclosure
I authorise the following person to take messages regarding a reminder/change of appointment/clinical details relating to my healthcare (if you do not nominate someone below, we will only be able to speak with you regarding the above)

Name ……………………………………………………………………………..
Relationship …………………………… Phone #……………………………

Do you have private health insurance? Yes ☐ No ☐

Name of health fund ………………………………………
Membership number ……………………………………..
Approximate date joined ………………………………….

Does your insurance cover hospital? Yes ☐ No ☐
Does your insurance cover dental? Yes ☐ No ☐

Are there any excesses, restrictions or exclusions on this policy? Yes ☐ No ☐ (Please list)

This information is needed at your consultation and can be obtained in advance from your health fund

MEDICAL INFORMATION AND HISTORY

If you would prefer not to complete this section and wish to discuss your medical history in confidence with your surgeon, please initial here ……………………

Have you had/do you have ANY medical conditions? Yes ☐ No ☐
For example, diabetes, heart problems, epilepsy, asthma, osteoporosis etc.

Type of Illness	Approx Date of Onset	Still current?	Treating Doctor

Patient Name: …………………………………………………….

WTCS

Have you ever had an operation? Yes ☐ No ☐ *Please list*			
Operation	***Approximate Date***	***Any Complications?***	***Treating Doctor***

Height ……………………………….. *Weight ………………………………*

Are you taking ANY medications? Yes ☐ No ☐ *Including Aspirin, other blood thinners or Osteoporosis medication or "natural" therapies*		
Medication Name	***Strength***	***When taken?***

Do you smoke/previous smoker? *How many? ………….*	Yes ☐ No ☐
Have you EVER had a general anaesthetic?	Yes ☐ No ☐
Have you or your relatives had any difficulty with a general anaesthetic? *If yes, please give details*	Yes ☐ No ☐
Are you under treatment for psychological problems?	Yes ☐ No ☐
For women, could you be pregnant?	Yes ☐ No ☐
Have you undergone neurosurgery before 1988?	Yes ☐ No ☐
Have you been treated prior to 1986 with pituitary hormone for growth or fertility?	Yes ☐ No ☐
Have you received corneal grafts?	Yes ☐ No ☐
Have you or any of your relatives suffered from CJD (Creutzfeldt-Jakob Disease) or other related diseases?	Yes ☐ No ☐
Do you have any allergies to food or medications? *If yes, please give details and reaction details*	Yes ☐ No ☐

Allergy	*Details of Reaction*

Thank you for supplying this information. It will help us treat you as safely and efficiently as possible. It is necessary for us to collect and pass on information from patients and sometimes others associated with your care in order to attend to your health needs, and for associated administrative purposes. You have access to any personal information of yours that we hold, and the right to know how that information is used. Please ask us if you would a copy of our Privacy Policy or if you have any concerns regarding this process.

*Please CIRCLE if you have assigned **POWER OF ATTORNEY** or have an **ADVANCED HEALTH DIRECTIVE***

- *I accept responsibility for the information provided above, for agreement to the treatment plan.*
- *I accept responsibility for payment of all accounts. Payments for consultations are required on the day. Unless otherwise arranged, payments for surgery in hospital are to be made within 10 days and claims to Medicare and/or health Funds are to be submitted after payment is receipted.*
- *I understand that payments not made on time may be subject to collection charges.*

Signature (patient/person responsible): ………………………………… Name: ……………………………………… Date: ……………………