north east nurse practitioner services

Timely response to your health needs

New Patient Form

Title: Mr / Mrs / Ms / Miss/ Master / other: _____

Gender: Male ☐ Female ☐ Intersex/Other ☐ Transgender ☐ Not Stated

First Name: _____ **Surname:** _____

Date of Birth: _____ /_____/_____

PLEASE SELECT ONE: Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither ☐

Cultural & Ethnic Background: Australian ☐ Other:_____

Country of Birth: Australia ☐ Other: _____ English Speaker: Y / N

Preferred Language: _____

Medicare Number: __ __ __ __ __ __ __ __ __ __ Reference No. ( )

Expiry Date: _____/_____/_____ **Pension Card/HCC:** Y / N Number: _____

Veterans Affairs Y / N Number: _____

Address: _____

Town: _____ **State:** _____ **Post Code:** _____

Home Phone: _____ **Work Phone:** _____ **Mobile:** _____

Email Address: _____

NEXT OF KIN (all patients): Same as Parent/Guardian, ☐ or:

First Name: _____ **Surname:** _____

Known as: _____ **Phone Number:** _____

Relationship to Patient: _____

EMERGENCY CONTACT (all patients): Same as Next of Kin ,☐ or:

First Name: _____ **Surname:** _____

Known as: _____ **Phone Number:** _____

Relationship to Patient: _____

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Timely response to your health needs

Consent Form

Please read this consent form carefully, and sign where indicated below.

As a patient of our medical practice, we require you to provide us with your personal details and a full medical history, so that we may properly assess, diagnose, treat and be proactive in your health care needs. We aim to protect the privacy of your health information. We require your consent to collect your personal information, and for its use in the following ways:
• Administrative purposes.
• Billing purposes (including compliance with Medicare and Health Insurance Commission requirements).
• Disclosure to others involved in your healthcare. This includes your treating doctor and specialists outside this medical practice. This may occur though referrals to other doctors, or for medical tests and in the reports or results returned to us following referrals.
• Disclosure to other doctors/nurse practitioners/allied health in the practice for the purpose of patient care and teaching.
• For research and quality assurance activities to improve individual and community health care and practice management. Only information that does not identify you is used in these circumstances.
• To comply with any legislative or regulatory requirements, such as notifiable diseases. • For reminders and recalls which may be sent to you regarding your health care and management. You can decline to have your health information used in all or some of the ways outlined above but it may influence our ability to manage your health care to provide the best outcome for you.

- **I have read the information above and understand the reasons why my information must be collected.**
- **I understand that I am not obliged to provide any information requested of me, but failure to do so may compromise the quality of health care and treatment given to me.**
- **I am aware of my rights to access the information collected about me, except in some circumstances where access may be legitimately withheld. I will be given an explanation in these circumstances. I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.**
- **I consent to the handling of my information by the practice for the purpose set out above, subject to any limitations on access or disclosure of which I notify this practice.**
- **I consent to SMS text message appointment reminders to be sent to my mobile phone.**
- I consent to SMS notifications to be sent to my mobile phone. or alternatively, I am unsure whether to these consents and would I like to discuss this further with someone from the medical practice before I decide to sign.

Patient Name: .....

Date : ...../...../.....

Patient Signature: .....

Signed as Guardian for Child: .....

Name of Guardian: (PRINTED) .....

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Patient Health History Form

Allergies: Do you have any allergies or are you sensitive to drugs or dressings?

No / Yes **Please elaborate:**

Drug, Dressing or Substance	Reaction (e.g. rash, hives, wheeze, shortness of breath, anaphylaxis)

Smokes & Vapes: ☐ Never smoked ☐ Ex-smoker (Please answer questions below)

☐ Smoker (Please answer questions below)

☐ Number of cigarettes when you do/did smoke? ..... per day or ..... per week

Alcohol: ☐ Never ☐ Yes

☐ Less than monthly ☐ Monthly ☐ 2-4 times a week ☐ 2-3 days per week

☐ 3-4 days per week ☐ 4 or more days per week ☐ Daily

History: Have any family members (other than yourself) had any of the following medical problems? If yes, please tick the box and please elaborate:

☐ High Blood Pressure _____ ☐ High Cholesterol _____

☐ Diabetes_____ ☐ Thyroid Disease _____

☐ Heart Disease _____ ☐ Stroke _____

☐ DVT or Lung Clots_____ ☐ Cancers _____

☐ Melanoma _____ ☐ Skin Cancer _____

☐ Osteoporosis _____ ☐ Varicose Veins _____

☐ Migraines _____ ☐ Mental Illness _____

☐ Other: _____ _____

_____ _____

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Past Medical History:

Do you have or have you had a history of the following? (Please elaborate)

☐ Surgeries ☐ Asthma ☐ Diabetes

☐ High Blood Pressure ☐ Chronic Illness ☐ Other

Current Medications :

Please list all current medications, doses and frequency of use including over the counter medications, vitamins and minerals:

.....

.....

.....

For those 65 years and older: When was the last time you were immunised?

Influenza: Date: ...../...../..... ☐ Not sure ☐ Never

Covid: Date: ...../...../..... ☐ Not sure ☐ Never

Have you had the following immunisations? (List the date where appropriate)

Tetanus Booster	Yes ☐ Date: ..../..../.....	☐ No	☐ Don't know
Whooping Cough	Yes ☐ Date: ..../..../.....	☐ No	☐ Don't know
Hepatitis A	Yes ☐ Date: ..../..../.....	☐ No	☐ Don't know
Hepatitis B	Yes ☐ Date: ..../..../.....	☐ No	☐ Don't know
Influenza	Yes ☐ Date: ..../..../.....	☐ No	☐ Don't know
Pneumococcal	Yes ☐ Date: ..../..../.....	☐ No	☐ Don't know
Measles, Mumps, Rubella	Yes ☐ Date: ..../..../.....	☐ No	☐ Don't know
Japanese Encephalitis	Yes ☐ Date: ..../..../.....	☐ No	☐ Don't know
Yellow Fever	Yes ☐ Date: ..../..../.....	☐ No	☐ Don't know
Meningococcal: B / C/ ACWY	Yes ☐ Date: ..../..../.....	☐ No	☐ Don't know
HPV	Yes ☐ Date: ..../..../.....	☐ No	☐ Don't know
Shingrix	Yes ☐ Date: ..../..../.....	☐ No	☐ Don't know

Measurements: Height: ..... cm; Weight: ..... kg;

What was your last blood pressure reading? ...../.....