New Patient Information Form

COLLABORATIVE HEALTHCARE

We are committed to providing our patients with the best care. To do this, it is essential that your health record contains complete and accurate information. Please assist us by completing your new patient record form:

Contact Information

Title:

Surname:

First Name:

Date of Birth: Sex: ☐ Male ☐ Female

Gender Identity: Pronouns:

Street Address:

Postal Address:
(if different to above)

Home Phone: Mobile Phone:

Do you consent to receiving SMS: ☐ No ☐ Yes Email:

Occupation:

Healthcare Identifiers

Medicare Number: _____ Ref: _____ Expiry: ___/_____

Dept. of Veterans' Affairs File Number: _____ ☐ Gold ☐ White

Concession (Pension/Health Care) Card Number: _____ Expiry: ___/_____

Private Health: ☐ No ☐ Yes Health Fund Name: _____ Membership No: _____

Next of Kin

Name: Relationship to You:

Home Phone: Mobile Phone:

If the patient is a child, is there currently any court orders in place relating to custody we should be aware of? ☐ No ☐ Yes

Emergency contact details

Name: Relationship to You:

Home Phone: Mobile phone:

T 9443 2507
E reception@collabhealthcare.com.au
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Formally trading as Joondanna Medical Centre

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Cultural identity

To assist with health initiatives- are you aboriginal/or Torres Strait Islander?

☐ No ☐ Yes – Aboriginal ☐ Yes – Torres Strait Islander ☐ Yes – both

Country of birth: _____

Ethnicity: _____

Do you require an interpreter service? ☐ No ☐ Yes

Your Health Information

ALLERGY INFORMATION - Do you have any allergies or are you sensitive to drugs or dressings?

☐ No ☐ Yes – please state reaction and severity:

_____

_____

CURRENT MEDICATIONS – Please list all your current medications, including complementary and over-the-counter medicines (e.g. homeopathic medicines such as vitamins and minerals etc.)

_____

_____

MEDICAL HISTORY - Do you have or have you had a history of the following?

☐ Asthma ☐ Hypertension ☐ Diabetes

☐ Chronic Illness ☐ Other – provide details: ☐ Surgery – provide details

_____

Your Health Information

LIFESTYLE RISK FACTOR INFORMATION

Weight _____

Height _____

Smoking

☐ No

☐ Ceased – date:_____

☐ Yes - how many: ____ /per day _____/year started

Alcohol

☐ No

☐ Yes - how many: _____/drinks per day _____/days per week

Recreational Drug Use

☐ No

☐ Yes, type: _____

frequency: _____

Family Health History Information

Do any of your family members have: (please specify who)

☐ Heart Disease _____

☐ Asthma_____

☐ Diabetes_____

☐ Hypertension (high blood pressure) _____

☐ Mental Illness_____

☐ Cancer – type: _____

☐ Other significant - provide details:

_____

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