NEW PATIENT FORM

Surname (Mr/Mrs/Miss/Ms): (Surname on Medicare Card)	Given Names (Given Name on Medicare Card)
Preferred Name:	**Date of Birth:**

Male ☐ **Female** ☐

Street Address					
Suburb		**State**		**Postcode**	
Postal Address (if different)					
Email Address:					
Mobile Phone		Home Phone		Work Phone	
Reminders & Recalls	I understand that Silky Oaks Medical Practice will sms me for appointment reminders and recalls. No medical information Will be included in these.			☐ Consent to SMS reminders	

Medicare Number	#	Ref#:	Expiry:
Guardian Medicare #	☐ As Above Other:	Ref#:	Expiry:
DVA	#	Colour:	Expiry:
Pension/HCC	#	Type:	Expiry:
Private Health Insurer	Fund:	#	Expiry:

Do you identify yourself as being of Aboriginal Yes/No or Torres Strait Island decent? Yes/No

Ethnicity		**Country of Birth**	
Religion		**Marital Status**	
Occupation			

How did you hear about us?

❑ Google/Bing ❑ Health Engine ❑ Word of Mouth ❑ Facebook

❑ Magnet/Flyer ❑ Yellow Pages ❑ Referral ❑ Walked in/Signs

Next of Kin	Name:	Relationship:	(Ph):

Have you previously registered for My Health Record?	
Would you like to be registered?	

Please continue over the page…..

MEDICAL INFORMATION

Initial Screening	Allergies and Reaction	Lifestyle Risks
Height _____ **Weight** _____ **BMI** _____ **BP** _____	*Please note **ALL** Allergies and Reaction.*	**Alcohol** ___ *per day/week/month* _____ *Quit* **Tobacco** ___ *per day/week/month* _____ *Quit* **Social History** (E.g. Sports, Hobbies, etc.) **Nutrition** (E.g. Vegetarian)
Active/Past Medical History	**Family History**	**Immunisations History**
Please note any relevant medical history e.g. Surgery, Cancer, Blood Pressure, etc.	*Please note any relevant medical history e.g. Cancer, Blood Pressure, Deceased, etc.* **Mother** **Father** **Siblings & Others**	

New Patient Consent Form for Electronic Transfer of Prescriptions

Name: ……..

ELECTRONIC TRANSMISSION OF PRESCRIPTIONS

I ……. have read the attached information sheet and **give/do not give** consent to any doctor at Silky Oaks Medical Practice to forward my prescription information electronically.

I understand that this information will be held electronically in a central environment and can be accessed at any time by any pharmacist I choose to process my prescription.

Signature: …… Date: ……

DE-IDENTIFIED DETAILS FOR CLINICAL AUDITS

I ……. have read the attached information sheet and **give/do not give** consent to any doctor at Silky Oaks Medical Practice to use my de-identified medical details for clinical audits.

Signature: …… Date: ……