Wahroonga Family
MEDICAL PRACTICE
*A team you can trust*

# NEW PATIENT DETAILS FORM & CONSENT

**We are committed to providing our patients with the best of care. It is essential that your health record is kept up to date and is accurate. Please complete the ENTIRE form and be advised that each and every visit you will be asked you name address, and phone number to ensure ongoing accuracy of your health record.**

**Title** (Please Circle): Mr Mrs Miss Ms Mstr Dr Prof **Date of Birth:** ___ ___ /___ ___/___ ___ ___ ___

**Surname:** _____ **First Name:** _____

**Middle Name:** _____ **Preferred Name:** _____

**Birth Sex:** _____ **Gender Identity:** _____

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

**Home Phone:** _____ **Email:** _____

**Street Address:** _____

**Suburb:** _____ **State:** _____ **Postcode:** _____

**Are you Aboriginal or Torres Strait Islander (Please Circle):** Yes / No

**Ethnicity/Cultural Background:** _____

**Do you require an interpreter?** Yes / No

**Medicare Number:** _____ **IRN:** _____ **Expiry Date:** _____

**DVA Number ( Gold / White ):** _____ **Expiry Date:** _____

**Centrelink Pension Number:** _____ **Expiry Date:** _____

**Health Care Number:** _____ **Expiry Date:** _____

**Seniors Health Card:** _____ **Expiry Date:** _____

**NEXT OF KIN (NOK) - The person we can contact if needed:**

**Full Name:** _____ **Phone:** _____ **Relationship:** _____

**EMERGENCY CONTACT - The person we can contact if different from NOK:**

**Full Name:** _____ **Phone:** _____ **Relationship:** _____

**PLEASE READ CAREFULLY**

**I consent to be contacted by phone by WFMP regarding my test results, reports and preventative health reminders This includes SMS reminders for appointments and check-ups. It is WFMP Policy that results requiring following up as per your doctors request deemed "clinically significant" our practice staff will contact you to book a follow up appointment for results. Please tick if you consent for WFMP to contact you regarding your results and reminder?**

☐ Yes ☐ No

**I understand that fees are payable at the time of consultation. A cancellation fee will apply if I fail to attend an appointment or cancel an appointment without prior notice. Non-payment of fees will result in a surcharge to cover cost of debt recovery.**

PATIENT SIGNATURE: _____ DATE: _____

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# PATIENT MEDICAL HISTORY

**The information we collect on this form is used to ensure we can correctly identify you each time you attend or contact the practice. We ask that you provide a full medical history to your doctor, so that we may properly assess, diagnose, treat and be proactive in your health care needs.**

**Full Name**: _____ **Date of Birth**: ___ ___ /___ ___/___ ____ ___ ____

**Do you smoke? (please circle):** Yes / No **If yes, how many cigarettes per day**: _____

**Ex-Smoker; how long ago did you quit?** _____

**Do You Drink Alcohol?** Yes / No / Social **If yes how often?** _____

**Do you have any ALLERGIES?** Nil known / Yes (please specify): _____
**(please circle)**

**FAMILY HISTORY – Does your mother/father have a history of any of the following?**

Diabetes: _____ Cancer: _____

Heart Disease: _____ Depression: _____

Stroke: _____ Hypertension: _____

Other (please specify): _____

Are you taking any medications currently (please list all including over the counter, prescribed medications, and alternative medications):_____
_____

**Please ask reception for a copy of WFMP personal information collection and use policy and the recall and reminder policy should you wish to read further about data collection and our recall systems within our practice.**

I (Print Name) _____ give my consent to be treated for my health related concerns at Wahroonga Family Medical Practice.

Signature of Patient: _____ Date: _____

**PLEASE GIVE RECEPTION YOUR SIGNED FORM, ALONG WITH PHOTO ID, TO COMPLETE YOUR BOOKING.**

**WFMP STAFF TO COMPLETE THIS SECTION**

_____

Completed by:
_____ Date: _____