New Patient Information Form

We are committed to providing our patients with the best care.
To do this, it is essential that your personal information is up to date and accurate.

Knightsbridge Medical Centre
knightsbridge.mc@gmail.com

SURNAME			*** MISS * MS * MRS * MR * DR**
FIRST NAME			
DATE OF BIRTH			
MEDICARE NUMBER		**Ref No.**	**Expiry Date**
***DVA Gold / White (Please Circle)**		**Expiry Date**	
*** CONCESSION CARD eg: Pension/HCC/Seniors HCC**		**Ref No.**	**Expiry Date**
RESIDENTIAL ADDRESS			
POSTAL ADDRESS			
MOBILE PHONE	**HOME PHONE**		
EMAIL ADDRESS			
MARITAL STATUS			
OCCUPATION			
COUNTRY OF BIRTH	**ETHNIC BACKGROUND**		

*DETAILS OF YOUR **NEXT OF KIN***		*DETAILS OF YOUR **EMERGENCY CONTAC T***	
* NAME	**D.O.B** ____________	* NAME	**D.O.B** ____________
* RELATIONSHIP TO PATIENT		* RELATIONSHIP TO PATIENT	
* ADDRESS		* ADDRESS	
* PHONE NUMBER (H)	(M)	* PHONE NUMBER (H)	(M)

DO YOU IDENTIFY AS BEING:

Aboriginal ? ☐ Yes ☐ No
Torres Strait Islander ? ☐ Yes ☐ No
Other Cultural Group (Please state) ________________________

CONSENT

I give consent and understand the reasons why my information must be collected, and the purposes for which my information may be used or disclosed. I understand that if my information is to be used for any purpose other than that set out, my further consent will be obtained. I also give permission for my personal information to be collected, used and disclosed as described above, including contact via SMS to my mobile phone number. I understand only my relevant personal information will be provided to allow the above actions to be undertaken and I am free to withdraw, alter or restrict my consent at any time by notifying this practice in writing.
This information may be shared with other providers involved your care. Our Privacy Policy is available at reception

Signature: ____ Date: ______________________________________

If not patient signing - your name (please print) ____

Your relationship to patient (e.g. Mother, Father, guardian) ____

How did you hear about us (Please circle)
Internet   Letterbox Drop   Word of mouth   Advertising   Current patient   ☐ Photo ID checked by staff

Medical Information Form

CONTACT INFORMATION

Full name:		Date of Birth:
Email:		Ethnic Background:

YOUR HEALTH INFORMATION

Allergies: Do you have any allergies or are you sensitive to drugs or dressings?
☐ No ☐ Yes – details:____

Smoking: ☐Non-smoker	☐Ex-Smoker No. of cigarettes____ Year commenced _____ Year Quit___	☐Smoker Frequency: ☐daily ☐Weekly ☐ less than weekly Year started_______ No. of cigarettes_____

Alcohol:

1.How often do you have a drink containing alcohol?
☐Never ☐4 or more time a week ☐2-4 times a month
☐ 2-3 a week ☐Monthly or less
2.How many standard drinks containing alcohol would you have on a typical day?
☐1 or 2 ☐3 or 4 ☐5 or 6
☐7 to 9 ☐10 or more
3.How often do you have 6 or more drinks on one occasion?
☐Never ☐Less than monthly ☐ Monthly
☐Weekly ☐Daily or almost daily

Physical Activity:

How many times a week do you do 20 minutes of vigorous physical activity that makes you sweat/puff/pant?_______

How many times a week do you usually do 30 minutes of brisk walking or moderate physical activity that increases your heart rate or makes you breathe harder than normal? ___________

Do any members of your family have:

Please state your family relationship: i.e. mother, father, brother, sister, aunt, uncle, etc

☐Asthma ___________________________
☐Diabetes ___________________________
☐High Blood Pressure ___________________________
☐Heart Disease ___________________________
☐Mental Illness ___________________________
☐Cancer - ____________________________
Type:____