NEW PATIENT REGISTRATION FORM

Title: _____ **Surname:** _____ **First name:** _____ **Middle name:** _____

Date of Birth: ____/____/____ **Gender Identity:** _____ **Pronouns:** _____

Medicare or DVA numb: _____ **IRN:** _____ **Expiry date:** _____

Pensioner Card/Health Concession Card number: _____ **Expiry date:** _____

Ethnicity (please tick): ☒Aboriginal ☐Torres Strait Islander ☐Both Aboriginal and Torres Strait Islander

☐Australian (non-Indigenous) ☐ Other: Country of birth: _____

Is English your main speaking language? YES / NO **If not, what is your main language:** _____

Do you require an interpreter? YES / NO

Home Address: _____ **Suburb:** _____ **Postcode:** _____

Mailing Address: _____ **Suburb:** _____ **Postcode:** _____

Are you a resident of Kununurra? YES / NO **If no, what is your expected length of stay:** _____

Address in Kununurra *(if different to home address)* _____

Mobile phone number: _____ **Are we able to contact you by SMS? YES / NO**

Work phone number: _____ **Email Address:** _____

Next of Kin: _____ **Relationship:** _____ **Contact Number:** _____

Emergency Contact: _____ **Relationship:** _____ **Contact Number:** _____

Usual GP name: _____ **Usual GP Location:** _____

By becoming a patient of Wunan Health and signing this new patient form I agree/consent to the following:

- ✓ *I consent to the use of my personal health information by Wunan Health and other health care providers involved in my medical treatment and health care within this centre.*
- ✓ *I consent to the disclosure of my personal health information by Wunan Health to other health care providers involved directly or indirectly involved in my personal health care or medical treatment.*

Declaration: *(Please tick boxes)*

☐ I understand that any fees incurred during my appointment/s today are payable at the end of my appointment/s

☐ I have seen and read the Patient Information Sheet

☐ I understand that certain medications (including pain patches, targin, endone, Valium, oxycontin, MScontin) will not be issued at an initial consultation

Signature: _____ **Date:** _____

Printed Name: _____

How did you find out about us? _____

PLEASE TAKE THIS SECTION TO THE DOCTOR/NURSE – all areas marked with a ** must be entered

This information is private and confidential and is for use in your clinical file only. Please give as much detail as possible to assist us to provide a high quality of care.

(Please circle the most appropriate answer or complete on line provided)
Title: Mr Mrs Ms Miss Dr Mast **Surname**: _____

First Name: _____ **Middle Name**: _____

Date of Birth: ___/____/_____

****FEMALE PATIENTS**: Date of last Pap Smear:_____ Where Performed: _____

**Result:_____

****ALL PATIENTS**: Please list any known **allergies** _____

Your **reactions: _____**The severity: _____

Do you know your **blood group**? Yes No If yes what group are you? _____

****Weight: _____kg** **Height: _____cm** **Waist Circumference: _____cm**

****FAMILY HISTORY: (Please circle the most appropriate answer or complete on line provided)**

Family History: Unknown (eg Adopted) Other – see list below

Mother: Still alive: Yes No If no, Age at Death: _____ Cause of death _____

Diabetes Asthma High Blood Pressure Heart Disease Stroke Depression Cancer – *please state* _____

Father: Still alive: Yes No If no, Age at Death: _____ Cause of death _____

Diabetes Asthma High Blood Pressure Heart Disease Stroke Depression Cancer – *please state* _____

Other immediate family significant illness: _____
Relationship:_____

****SOCIAL HISTORY: (Please circle the most appropriate answer or complete on line provided)**

**Do you drink alcohol? Yes No If yes, how many per day? _____ How many days per week? _____
**Past Alcohol History: Nil Occasional Moderate Heavy

**Do you smoke? Yes No If yes, how many per day?_____ Ex Smoker (Year stopped) _____

Your Current Medications and Doses:
_____

Please list any operations or previous illnesses:
_____

At Wunan Health we strive to provide high quality care, appropriate to meet our client's health care requirements. Your feedback is important to us. Please feel free to fill in a suggestions form at the front counter.