wunan HEALTH

NEW PATIENT REGISTRATION FORM

Title: _____ **Surname:** ________________ **First name:** _______________ **Middle name:** _________________

Date of Birth: ____/____/____ **Birth Sex:** __________ **Gender Identity:** ______________ **Pronouns:** ________

Medicare or DVA number: ____________________________ **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) ☐ 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 **Occupation:** __________________________________

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:** __________________________

How did you find out about us? ____

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

This information is private & confidential & 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.

Title: ☐Mr ☐Mrs ☐Ms ☐Miss ☐Dr ☐Mast ☐Other:........ **Surname:** ....

First Name:.. **Middle Name(s):**..

Date of Birth: ....../....../......

ALL PATIENTS TO FILL

Do you know your blood group? ☐Yes ☐No		If yes, what is your blood group?
Height:	Weight:	Waist Circumference:
*Any known allergies:		
*Your Reaction:	*Severity:	
Your current medications & doses:		
Please list any operations or previous illnesses:		

*For Female Patients	Date of Last Pap Smear:	*Result:
	Where was it Performed?	

*FAMILY HISTORY (Please ☒tick the most appropriate answer or complete on the line provided)

Are you ☐Adopted (Skip to Social History section) ☐Other (See list below)

Mother	Still Alive: ☐Yes ☐No	If No, Age at Death:	Cause of Death:
Health Conditions: ☐Asthma ☐H/Blood Pressure ☐Heart Disease ☐Stroke ☐Depression ☐Cancer type:			
Father	Still Alive: ☐Yes ☐No	If No, Age at Death:	Cause of Death:
Health Conditions: ☐Asthma ☐H/Blood Pressure ☐Heart Disease ☐Stroke ☐Depression ☐Cancer type:			

Other Immediate Family Significant Illnesses:	Relationship:

*SOCIAL HISTORY (Please ☒tick the most appropriate answer or complete on line provided)

Do you currently drink Alcohol? ☐No ☐Yes	How many days per week?	How many drinks per day?
Past Alcohol History: ☐Nil ☐Occasional ☐Moderate ☐Heavy		

Do you currently smoke cigarettes?	☐Yes	If yes, how many days per week?	How many smokes per day?
	☐No	Ex-smoker→Year Stopped:	

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 **Suggestion Form** available at the reception.*

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Wunan Health & Well-Being Centre is a multi-disciplinary and accredited private medical practice that serves the East Kimberley region.

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