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:** _____

**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 (incl headspace Kununurra, KWIC, Allied Health Project) 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 (incl headspace Kununurra, KWIC, Allied Health Project) 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

☐ **I give my consent to be contacted by SMS**

☐ **I do not wish to be contacted by SMS**

**Signature:** _____ **Date:** _____

**How did you find out about us?** _____

wunan HEALTH

## 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 or vape? | ☐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.*

T (08) 9168 1001
E reception@wunanheaith org.au
A 57 Bandicoot Dr, Kununurra WA 6743
P PO Box 1338, Kununurra WA 6743
www.wunan.org.au

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

ABN 61 577 218 739 | Charitable Collections Licence 20625