

NEW PATIENT REGISTRATION FORM

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

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

Medicare or DVA number: _____ IRN (number next to your name): _____ Expiry date: ____/____/____

Pensioner/Health Concession Card number (Please circle card type): _____ 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 services) 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 services) to other health care providers involved directly or indirectly involved in my personal health care or medical treatment.
- ✓ I understand that missed appointment fees may apply if I do not give the required notice (unless in the case of an emergency) of my intention to not attend my future appointment/s.

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? _____

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? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No	If No, Age at Death:	Cause of Death:
Health Conditions: <input type="checkbox"/> Asthma <input type="checkbox"/> H/Blood Pressure <input type="checkbox"/> Heart Disease <input type="checkbox"/> Stroke <input type="checkbox"/> Depression <input type="checkbox"/> Cancer type:			
Father	Still Alive: <input type="checkbox"/> Yes <input type="checkbox"/> No	If No, Age at Death:	Cause of Death:
Health Conditions: <input type="checkbox"/> Asthma <input type="checkbox"/> H/Blood Pressure <input type="checkbox"/> Heart Disease <input type="checkbox"/> Stroke <input type="checkbox"/> Depression <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> Yes	How many days per week?	How many drinks per day?
Past Alcohol History: <input type="checkbox"/> Nil <input type="checkbox"/> Occasional <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy		

Do you currently smoke or vape?	<input type="checkbox"/> Yes	If yes, how many days per week?	How many smokes per day?
	<input type="checkbox"/> 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.*