

Mosman Park Medical Centre
51 Harvey Street
MOSMAN PARK WA 6012
Ph: (08) 9384 4426 Fax: (08) 9385 6896

NEW PATIENT INFORMATION & CONSENT FORM – PLEASE COMPLETE BOTH SIDES

Family Name: _____	Title: <u>Dr / Mr / Mrs / Ms / Mast / Miss</u>
First names: _____	Preferred Name: _____
Date of Birth: ____/____/____	Gender: Male / Female
Aboriginal/Torres Strait Islander: YES / NO Australian: YES / NO Country of Origin: _____	
Address: _____	
Suburb: _____	Post code: _____
Phone No. (Home): _____	(Mobile): _____
Marital Status: _____	Occupation: _____

For children 18 years and under

Mothers Full Name: _____	Date of Birth: ____/____/____
Fathers Full Name: _____	Date of Birth: ____/____/____

Alternative Contact Details

Name of local Next of Kin or Friend: _____	Phone No.: _____
In case of Emergency name of local Contact : _____	Phone No.: _____
Relationship to patient: _____	Phone Number: _____

Medicare Card Number: _____	REF: _____	Card expiry date: _____
Private health fund: YES / NO	Name of fund?: _____	
Centrelink <u>HealthCare Card</u> : YES / NO	Number: _____	Exp: _____
Centrelink <u>Pensioner Card</u> : YES / NO	Number: _____	Exp: _____
DVA Card: YES / NO	Card Number: _____	Exp: _____
Select what colour DVA card you have: GOLD / WHITE / LILAC / ORANGE		

Please Turn Over and complete the Patient Health History

PATIENT HEALTH HISTORY:

Are you allergic to anything? YES / NO (Including medications).

Do you have? Asthma Diabetes Hypertension Heart Disease Depression/Anxiety
 Chronic Illness: _____

Have you been hospitalised or had any operations in the last 12 months? YES /NO

Are you a Smoker? YES / NO Cigarettes per Day: _____

Ex-Smoker? YES / NO Year Stopped: _____

Do you drink Alcohol? YES / NO How much: _____

Family History: Please tick relevant box

	Current ✓	Past ✓	Your Relationship to Patient (ie parents, grandparents, etc)
High blood pressure/Low blood pressure			
Heart/vascular disease			
Diabetes			
Liver or Kidney Disease			
Asthma/Lung Disease			
Bowel/Stomach Disease			
Stroke			
Anxiety/Depression			
Cancer			
Glaucoma			

CONSENT:

I understand that Mosman Park Medical Centre complies with the Privacy Act (1988) and as part of their Privacy Policy they are committed to protecting the privacy of individuals and their personal information. The purpose for collecting my personal information is to provide quality medical and health related services and associated account keeping. I understand that I have the right to request access to my information. Mosman Park Medical Centre makes every effort to manage my information in accordance with the National Privacy Principles and keep my records accurate and up to date. I understand that I may withdraw my consent for Mosman Park Medical Centre to use and disclose my personal information (except when legal obligations must be met).

I HAVE READ THE ABOVE AND CONSENT TO:

- 1) Mosman Park Medical Centre collecting, using, storing and disposing of my information.
- 2) The release of relevant personal information to other health professionals to allow quality medical care.
- 3) Inclusion in a recall register to be advised of follow up visits, medical updates & health information.
- 4) Please be advised that we are a Private Billing Practice and there will be a fee at the end of your consultation.

We are a Private Billing Practice and there will be a fee which will need to be settled on the day of your consult. A standard consultation is 15 minutes \$80 and a long consult is 15 to 30 minutes \$140. Your Medicare claiming will be processed automatically at the time of payment.

Signature: _____ **Date:** ____ / ____ / ____