MOSMAN PARK
medical centre

51 Harvey St
Mosman Park WA 6012
ABN: 74 060 136 085
Tel: (08) 9384 4426
Fax: (08) 9385 6896

NEW PATIENT INFORMATION & CONSENT FORM – PLEASE COMPLETE BOTH SIDES

Patient Family Name: _____ Title: Dr / Mr / Mrs / Ms / Mast / Miss

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. (Mobile): _____ Phone No. (Home): _____

Consent to receive SMS notifications: **YES** ☐ **NO** ☐ Email: _____

Marital Status: _____ Occupation: _____

Details of Parent/Guardian responsible for the account, for children 18 years and under

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

Contact Phone No: _____

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

Contact Phone No: _____

Alternative Contact Details

Next of Kin: _____ Phone No.: _____

Relationship to Patient: _____

Emergency Contact : _____ or as above

Phone No: _____ Relationship to patient: _____

Medicare Card Number: _____ REF: _____ Card expiry date: _____

Private health fund: YES ☐ **NO** ☐ Fund Name: _____ Member No: _____

Centrelink HealthCare Card: **YES** ☐ **NO** ☐ Number: _____Exp: _____

Centrelink Pensioner Card: **YES** ☐ **NO** ☐ Number: _____Exp: _____

DVA Card: **YES** ☐ **NO** ☐Card Number: _____ Exp: _____

Select what **colour DVA** card you have: **GOLD / WHITE / LILAC / ORANGE**

Authority to release for collection, Medical Information / Scripts / Referrals etc to a third party:
I authorise: ie parents/guardian; spouse/partner to collect medical correspondence on my behalf.

Patient Signature: _____Date: _____

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: _____

How did you hear about Mosman Park Medical Centre: _____

Your Family History: Please tick relevant box

	Current ✓	Past ✓	Relationship to You (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 $95 and a long consult is 15 to 30 minutes $160.
Your Medicare claiming will be processed automatically at the time of payment.

Signature: _____ Date: ____ /_____ /_____