O'Shea Medical Centre

2-6 Skyline Way, Berwick 3806
Phone: (03) 8786 9192 Fax: (03) 8786 7810

NEW PATIENT FORM

Personal Details:

Gender: _____

Title: _____ First Name: _____

Surname: _____ D.O.B: ____/____/____

Address: _____

Suburb: _____ Postcode: _____

Ph: (H) _____ (M) _____

Email: _____

Occupation: _____

Ethnicity/Background: _____

Marital Status: _____

Are you Aboriginal or Torres Strait Islander?

Yes ☐ No ☐

Medicare Details:

Medicare Number: _____

Reference No. (in front of name) ☐ Expiry: _____

Concession Card No.: _____

Expiry Date: ____/____/____

Concession Card Type: _____

If DVA, which one? **ORANGE** **WHITE** **GOLD**

Allergies:

Do you have Allergies or Sensitivities to any Medication?

Yes ☐ No ☐

If yes, please list: _____

_____

Emergency Contact Details:

Next of Kin: _____

Relationship: _____ Contact: _____

Emergency Contact: _____

Relationship: _____ Contact: _____

How did you hear about us?

Word of Mouth Flyer Facebook

Internet Yellow Pages Drive Past

Family History:

If your parents are deceased please state the cause of death and at what age:

_____

_____

Has any member of your family been diagnosed with Diabetes, a Heart condition or any form of Cancer? If yes, please detail: _____

_____

Past History:

Have you ever been a patient in a Hospital? If so, for what reason and in which year? _____

_____

Are you a Diabetic: Yes ☐ No ☐ If yes,

Type 1 ☐ Type 2 ☐

When was your last Pap Smear? _____

Do you suffer from High Blood Pressure? Yes ☐ No ☐

Have you ever suffered from chest pain or shortness of breath? Yes ☐ No ☐

Social History:

Do you smoke? If yes, how many per day? _____

Have you previously smoked? If yes, when did you give up smoking? _____

Do you drink alcohol? If yes, how many days per week? _____

Privacy Agreement & Patient Consent:

I understand that O'Shea Medical Centre complies with the Privacy Act (1998) and as part of their Privacy Policy they are committed to protecting the privacy of individuals and their personal information. My signature below indicates that I have read the above and consent to O'Shea Medical Centre collecting, using, storing and disposing of my personal information to other Health Professionals to allow quality medical care, including a recall register to be advised of follow up visits, including National/State reminder systems/registers, medical updates and health information and the release of relevant personal information to my (prospective) employer, their authorised representative and their insurer in the case of a work related consultation or service. I understand that I may withdraw my consent for O'Shea Medical Centre to use and disclose my personal information (except when legal obligations must be met). For medico legal reasons it is a Policy of this practice that Doctors have the right to request a chaperone when examining patients of the opposite sex and unaccompanied children as deemed appropriate.

Signature: _____ **Date:** _____