"A Fresh Approach to Your Health and Skin Cancer Care"

Noosa Clinic

We are committed to providing our patients with the best care.
To do this it is essential that your contact details are kept up to date and accurate at all times.

Title	Mr Mrs Ms Master Miss Doctor					
Surname						
First Name						
Date of Birth		Do you identify with any specific cultural background? Aboriginal ☐ TSI ☐ No ☐ Other				
Street Address						
Suburb				Postcode		
Postal Address						
Phone Numbers	Home:	Mobile:		Work:		
Do you consent to us sending you SMS reminders to this mobile?		Yes		No		
Email address						
Medicare Number		Pt Ref No.		Expiry Date		
Pension or Health Care Card Number (Pls circle which)		Expiry Date				
DVA Gold or White Card Number		Expiry Date	If white card- what conditions:			
Private Health Cover Name		Hospital Cover (Please circle one level) • Basic • Intermediate • Top Or Ancillaries or Extras only (No hospital cover)				
Private Health Cover Member Number						
Marital Status	Single	Married	Widowed	Divorced	De facto	Separated
Occupation		Country of Birth				
Next of Kin	Name and telephone and their relationship to you					
Emergency Contact	Name and telephone if not NOK and their relationship to you					

THE PRIVACY ACT (2001)
We are committed to protecting your privacy. All information about you is kept in the strictest confidence and we operate in accordance with the Privacy Act (1988) and Privacy Amendment Act 2012. We are now asking for your consent for the use and disclosure of your health information as Required during your health care.

Full Name _____ **Signed** _____

On behalf of_____ **Date** _____

How did you hear about Noosa Clinic? ☐ Word of Mouth
☐ Website
☐ Newspaper advertising
☐ Family/friend referral
☐ Previous patient

Reminder Systems:

Our practice provides our patients with preventative care and early case detection reminders e.g. Immunisations, annual health checks, Skin checks and pap smears.

Do you wish to have relevant health reminders sent to you?

☐ Yes mail ☐ Yes, SMS to this phone number _____ ☐ No

Do you have any allergies or are you sensitive to drugs or dressings?

☐ **Yes (please list below)** ☐ **No**

_____

_____

Current medications (including over the counter medications, vitamins and minerals)

_____ _____

_____ _____

_____ _____

Family History- have any family members of your family had?

Asthma _____ **Heart Disease**_____ **Mental Illness** _____ **Cancer** _____

Social history:

☐ Tobacco _____ day / week or Ceased Smoking- date _____

☐ Alcohol _____ day / week / month (circle the one applicable)

Immunisation: have you had the following immunizations?

Tetanus booster	Date	☐ Don't know	☐ Haven't had one
Hepatitis B	Date	☐ Don't know	☐ Haven't had one
Hepatitis A	Date	☐ Don't know	☐ Haven't had one
Influenza	Date	☐ Don't know	☐ Haven't had one
Pneumococcal	Date	☐ Don't know	☐ Haven't had one
Polio	Date	☐ Don't know	☐ Haven't had one

Children's immunisations: if completing this form for a child are their immunisations up to date?

☐ Yes ☐ No

Practice Nurse:

HT ..... **WT** ..... **BP** ..... **EYES**..... **BGT**.....**H/A Booked**