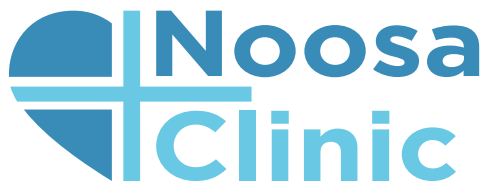


"A Fresh Approach to Your Health and Skin Cancer Care"



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 <input type="checkbox"/> TSI <input type="checkbox"/> No <input type="checkbox"/> 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)			
Private Health Cover Member Number			<ul style="list-style-type: none"> • Basic • Intermediate • Top Or Ancillaries or Extras only (No hospital cover)			
Marital Status	Single	Married	Widowed	Divorced	De facto	Separated
Occupation			Country of Birth			
Next of Kin	<u>Name and telephone and their relationship to you</u>					
Emergency Contact	<u>Name and telephone if not NOK and their relationship to you</u>					

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	<input type="checkbox"/> Don't know	<input type="checkbox"/> Haven't had one
Hepatitis B	Date	<input type="checkbox"/> Don't know	<input type="checkbox"/> Haven't had one
Hepatitis A	Date	<input type="checkbox"/> Don't know	<input type="checkbox"/> Haven't had one
Influenza	Date	<input type="checkbox"/> Don't know	<input type="checkbox"/> Haven't had one
Pneumococcal	Date	<input type="checkbox"/> Don't know	<input type="checkbox"/> Haven't had one
Polio	Date	<input type="checkbox"/> Don't know	<input type="checkbox"/> 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