"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 (Please circle)	Mr Mrs Ms Master Miss Doctor				
Surname		First Name			
Middle Name		Known As			
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		Private Health Cover Member Number			
Occupation / ADF Service		Country of Birth			
Head of Family (if under 17 yrs of age)	Name and telephone and their relationship to you DOB Medicare Ref Number				
Next of Kin / or Emergency Contact	Name and telephone if not NOK and their relationship to you				
My Health Record	Opt In Opt Out				
Do you wish to have relevant health reminders sent to you?	☐ Yes, SMS to this phone number _____ ☐ No ☐ Yes mail				

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** _____

Smoking: **Non-smoker** ___**Ex-smoker** ___ **Yr Ceased**_____**Smoker - how many per day** ___

Recreational Drugs Yes / No

Alcohol: Non-drinker _____ Number of days/ week _____ Standard drinks / day _____

Allergies: **No** **Yes** **Drugs: eg Sulphur/Penicillin** _____ _____

_____ _____

Others: eg Lactose/Gluten _____ _____

_____ _____

Please list any medications that you are currently taking, please include vitamins and herbal medicines:

Name of medication : _____**Strength:** _____ **Daily dose:** _____

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Name of medication : _____**Strength:** _____ **Daily dose:** _____

Past History-

Illnesses: eg Asthma/Diabetes/Epilepsy

_____ _____

_____ _____

_____ _____

Family History: eg Mother/Father/Siblings

_____

_____

As far as you know are your immunisations up to date?

☐ Yes ☐ No

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

☐ Yes ☐ No

Females: When was your last - Pap Smear _____

- Mammogram _____

How did you hear about Noosa Clinic?

- ☐ **Word of Mouth**
- ☐ **Website**
- ☐ **Newspaper advertising**
- ☐ **Family/friend referral**
- ☐ **Previous patient**