Robina Bulk Billing Medical Centre Date: / /

New Patient Details Form

Please circle…… Mr, Mrs, Ms, Mast, Miss, other _____

Family Name _____ First Name _____

Preferred Name _____ Date of Birth _____

Do you self-identify with any cultural background?

☐ Aboriginal ☐ Torres Strait Islander ☐ Other

Country of Birth? _____

Address: _____Suburb: _____

Postcode: _____ Home Phone: _____ Work: _____

Mobile: _____ ***We send SMS reminders 1 day prior to appointments**

Register an email address if you would like to do one of more of the following: (Please tick boxes)
□ I would like to have the ability to book my appointments online or via an App on my phone
□ I would like to go on the Robina Bulk Billing Medical Centre mailing list
□ I would like to go on the Complimentary Health mailing list

(You can unsubscribe from these list/lists at any time).

Email address: _____

1. Are we able to leave a message on your answer phone regarding an appointment? Yes ☐ No ☐
2. Are we able to leave a message regarding your appointment to another member of your family? Yes ☐ No ☐
   If 'yes' please state who and the phone number: _____

Medicare Card number: _____Your ref. on card _____ Expiry Date: _____

Pension Card No. _____ Expiry Date: _____

Healthcare Card No. (Concession Card) _____ Expiry date: _____

DVA Card no. _____ Gold / White / Lilac / Purple (please circle) Conditions: _____

Next of Kin Name: _____ Phone: _____ Relationship: _____

Emergency Contact Name: _____Phone: _____ Relationship: _____

Cancellations: If you are unable to attend your appointment please contact the practice at least four hours before the appointment time to cancel, so that we may offer the appointment to another patient. If you do not let us know that you do not require your appointment a $30 fee may be required to be paid prior to your next appointment.

We value your privacy. All information about you at Robina Bulk Billing Medical Centre (RBBMC) is kept in the strictest confidence and we operate in accordance with the Privacy Act (1988). We are committed to protecting your privacy and ask for your consent for the use and disclosure of your personal health information during your healthcare.

□ I consent to the disclosure/use of my personal health information by RBBMC to other health providers directly or indirectly involved in my personal health care or medical treatment. I acknowledge that I am wholly responsible to arrange any further appointments to discuss test results conducted by my Doctor at all times. (If you do not understand this information please ask one of our receptionists to explain this to you to your satisfaction).

Signed: _____ Please tick if ☐ Parent ☐ Guardian

How did you hear about us? (Please tick)

☐ Phone Book ☐ Internet ☐ Family / Friend ☐ Signage ☐ Website ☐ Other

ROBINA BULK BILLING MEDICAL CENTRE Date: / /

PATIENT MEDICAL HISTORY FORM

Robina Bulk Billing Medical Centre take their role as your primary healthcare provider very seriously. The more information we have about you, the more effective the management of your health will be. We aim to identify common health problems as early as possible so as to minimize their effects, and avoid ill-effects caused by not knowing about current illness, past illness or medication. All information is kept private and confidential.

PATIENT NAME: _____

Date of Birth: _____ **PHONE NUMBER: _____**

Who is or was your regular GP? Leave blank if you do not have one.
Name:_____
Address: _____
Phone:_____

Do you want us to be your regular GP? [circle response] YES or NO
**** If yes, please fill out request for medical records form**

Medical History

Do you have any allergies? _____

Have you ever had, or currently have any of the below? Please circle.

- Heart trouble
- Diabetes Type 1 ☐ Type 2 ☐
- Epilepsy
- Migraine
- Cancer
- Hep A, Hep B, Hep C
- Asthma
- Depression or Mental illness
- Indigestion or reflux
- Back Pain or arthritis
- Diarrhoea or bowel trouble
- Hiv

Other illnesses? _____

Please circle if you have any family history of: **DIABETES** **HEART DISEASE** **DVT**

Any operations? (please list with dates and any complication, Spelling immaterial!)) YES or NO

_____
_____

Any medications? (please list the name of the medication)
Remember-aspirin, health food supplements & over the counter purchases are medicines.

_____
_____
_____

Smoking please circle Ex-smoker quit date _____ Never 2-3/day 10/day 20/day

Alcohol please circle NONE Daily 1-2 days/wk 3-4 days/wk 1-2 days/mth 1-2 days/year

Standard drinks per day _____

Height: _____ Weight: _____

Women: Date of Last Pap Smear: _____ Was it normal (please circle) Yes or No

If you have children are they up to date with their immunisations? Yes or No

BRING YOUR CHILDCARE BOOK TO UPDATE OUR RECORDS WITH OUR NURSE