KARRINYUP St Luke MEDICAL CENTRE

1/57 Burroughs Rd, Karrinyup WA 6018 Tel: 08 9341 7770 Fax: 08 9341 7771

This information is private and confidential and is for use in your clinical file only
Please print and give as much detail as possible to assist us to provide quality care.

NEW PATIENT DETAILS *(PLEASE FILL OUT BOTH PAGES OF THE FORM)*

Full name: Mr Mrs Ms Miss Dr Surname: _____ First Name: _____ Middle Name: _____

Preferred Pronoun's: (She/Her/Hers), (He/Him/His), (They,Them,Their's)

Date of Birth ___/____/_____ Preferred Name_____ Male/Female _____

Ethnicity: Aboriginal TSI ATSI Other _____

Country of birth: _____

Occupation _____

Address: _____

Suburb: _____ Postcode: _____

Home Phone: _____ Mobile: _____ Work _____ if contactable yes/no

Email Address: _____

Preferred Method of Contact (please circle): Mobile SMS Email Home Phone Work Phone

Do not Consent to SMS ☐

Medicare No:_____ Ref no _____ (next to name) Expiry date_____

Pension or Healthcare [circle] Card No._____ Expiry_____

Vet Affairs No: :_____ Expiry date_____

Private Health Ins (HBF,Bupa, Medibank etc)_____

Next of Kin _____ Relationship _____Phone _____

Emergency Contact_____ Relationship: _____

Phone No: _____ Mobile Phone No: _____ Business: _____

PLEASE COMPLETE SECOND PAGE:

Please note: A $20 non attendance fee will be charged if an appointment is missed or is not cancelled within a reasonable time frame.

MEDICAL HISTORY - PLEASE TAKE THIS SECTION TO DOCTOR

Full name: Mr Mrs Ms Miss Dr Surname: _____ First Name: _____ Middle Name: _____

Date of Birth ___/____/_____

Current Medications and Doses_____

Please list any known allergies and your reactions or list nil known if none_____
_____

Please list any operations or previous illnesses_____

***FEMALE PATIENTS*: Date of last Pap Smear_____ Result_____**

FAMILY HISTORY: Please circle ◯ the most appropriate answer complete all other areas Family History:
Unknown (eg Adopted) No significant family history Other – see list below

Mother: Still alive: Yes / No If no Age at Death: _____
Diabetes Kidney Disease Asthma High Blood Pressure Heart Disease Heart Problems Breast Cancer Stroke Depression Epilepsy Other Cancer

Father: Still alive: Yes / No If no Age at Death: _____
Diabetes Kidney Disease Asthma High Blood Pressure Heart Disease Heart Problems Stroke Depression Epilepsy Prostate Cancer Other Cancer
Other immediate family members significant illness_____

SOCIAL HISTORY: Please circle the most appropriate answer fill out all other areas

Do you drink alcohol? Yes / No If yes how many days per week? _____ How many Drinks per day?_____
Past Alcohol History: Nil Light Moderate Heavy

Do you smoke? Yes / No If yes how many per day? _____Past Smoking History: Nil Light Moderate Heavy
Which year did you stop smoking? _____

Do you know your blood group? Yes No If yes what group are you? _____

By becoming a patient of Karrinyup St Luke Medical Centre and signing this new patient form I agree and consent to the following:
I consent to the use of my personal health information by Karrinyup St Luke Centre and other health care providers involved in my medical treatment and health care within this centre.
I consent to the disclosure of my personal health information by the above named practice to other health care providers involved directly or indirectly involved in my personal health care or medical treatment.
As part of preventative health services offered by this practice we send out follow up reminders and recalls when routine investigations are due. I consent to receive follow up reminders and recalls to be sent to the above address.
Test Results: It is the policy of the practice not to inform you of any pathology or specific test results over the phone for privacy reasons.We will advise you if you need to make an appointment to discuss results of any recent tests you have had done if the GP requests this. Otherwise if you have been encouraged to review any tests the GP has asked you to undertake, it is up to you the patient to make a follow up appointment. No results will be given to a third party unless exceptional circumstances

Signature_____ Date_____/_____/_____

Printed Name _____

At Karrinyup St Luke Medical Centre we strive to provide high quality care, appropriate to meet our client's health care requirements.