MAPLE STREET SURGERY

New Patient Form/Transfer Authority

Title ……. First Name…….. Surname ……

Date of Birth ……..……..…. Male/ Female/Other……

Middle Name……..… Preferred Name …….

Occupation……. Name of employer……

Medicare No ☐☐☐☐☐☐☐☐☐☐ **Ref No** ☐ **Expiry date……**

Pension /Health Care Card No ☐☐☐☐☐☐☐☐☐☐ **Expiry Date……**

DVA No ……..Expiry date…….. White/Gold……..……

Do you identify as; Aboriginal, Torres Strait Islander, Other ……(please circle/name)

Address……..

Suburb……Post code……..

Phone No's (home)…… Work……Mobile……..……..…..

Email……..……

Country of Birth……

I acknowledge that I may be contacted by email, phone or text.

Next of Kin…… Relationship to you……

Phone No ……

Emergency Contact……..Phone Number……..…..

Dear Patient

Your doctor will make independent professional decisions to optimize your clinical outcome. We value and respect your privacy.

I consent to the disclosure of my personal health information by doctors practicing at Maple Street Surgery to other health care providers directly or indirectly involved in my personal health care or medical treatment. I consent to de-identified data (including, without limitation, photographs of my skin and any skin cancers) being used for medical training and medical research by Maple Street Surgery and such data being provided to third parties for these same purposes.

Your personal health information will not be sold by this practice to marketing companies and cannot be used for the purpose of promoting non-health related products or services.

FINANCIAL CONSENT: I have been advised of the estimated costs in respect of the proposed medical services. I accept responsibility for payment of this account, including (if applicable) if a nominated insurer does not pay the anticipated rebate.

PERSONAL DECLARATION I have read and understood the information provided above

…… **AND/OR** ……

Signature Patient/ Parent/ Guardian Signature

Print Full Name Patient/Parent/Guardian
ONLINE PATIENTS TYPE FULL NAME HERE

Date……/……/……

Your Health History

Have you had any operations in the past?

Describe type…… What year ……

Do you suffer from any of the following (please X):

c Diabetes c Blood Pressure c Heart Disease c Asthma c Other

Do you have any allergies: Yes/No.

Allergy…… Reaction: Mild/Severe

Allergy…… .. Reaction: Mild/Severe

Allergy…… Reaction: Mild/Severe

Have any members of your family (please x);

c Diabetes Father/Mother/Brother/Sister/Other.

c Blood Pressure Father/Mother/Brother/Sister/Other.

c Heart Disease Father/Mother/Brother/Sister/Other.

c Asthma Father/Mother/Brother/Sister/Other.

c Cancer (type) .....Father/Mother/Brother/Sister/Other

c Mental illness

Social History:

c Tobacco …… day/week, or, ceased smoking date ……..

c Alcohol …….. day/week

c Drug use type ……... Frequency per week……..

Height ……cm Weight …… kg

Females – when did you last have: Pap smear ……

Breast check ……...

Males – when did you last have: Prostate exam …….

Are your immunisations up to date: ……..

How did you hear about Maple Street Surgery?

- ☐ **Word of mouth**
- ☐ **Website**
- ☐ **Newspaper advertising**
- ☐ **Family/Friend referral**
- ☐ **Previous patient**
- ☐ **Other**

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- **Dr David Kirkman**
- **Dr Leon Venter**
- **Dr Tom Phillips**
- **Dr Aykari Lynn**
- **Dr Charlotte Byrne**
- **Dr Richard Simpson**
- **Dr Sue Fattah**
- **Dr Bushra Abbasi**

DATE: _____

PATIENT AUTHORITY TO SEEK PREVIOUS RECORDS

FULL NAME: _____

ADDRESS: _____

_____

DATE OF BIRTH: _____/'_____/_____

The patient named above is now attending Maple Street Surgery. Could you please send us a **summary of their medical history** via Medical Objects or fax?

NAME OF DOCTOR/PRACTICE: _____

ADDRESS: _____

_____

TELEPHONE: _____ FAX: _____

IN RELATION TO: Providing summary of their medical history to MSS

PATIENTS AUTHORISATION:

I hereby give my written permission for my records to be released to Maple Street Surgery.

Signature OR Full Name for online forms): _____

NOTE: A name typed by the patient and submitted online is a legally binding document.
Please phone the patient if you require further confirmation