

New Patient Information Form

Your first consultation is usually scheduled for up to 1.5 hours [if needed] to allow the doctors to create a comprehensive medical file and explore your health problems in detail. The duration of follow up appointments will depend on your health problem(s). They may range from 15-30-45 minutes. Your doctor will decide with you when they would like to review you again. Please bring any specialist reports, investigations or tests you had with previous doctors that may be useful for our doctors to view. Parking is available at the rear of the practice. Please arrive 15 minutes before your appointment and bring your completed registration form for the doctor to view.

We are committed to providing our patients with the best care. To do this it is essential that your health record is kept up to date and accurate.

Could you please assist us by completing the following?

Surname			
First Name			
Date of Birth:			
Street Address			
Suburb & Post Code			
Home Phone			
Work Phone			
Mobile Phone			
Email			
Medicare Number		Expiry Date	
DVA Gold / White (Please circle)		Expiry Date	
Pension Number		Expiry Date	
Health Care Card Number		Expiry Date	
Private Health Cover			
Next of Kin (Name and Phone number)			
Emergency Contact (Name and Phone number of the person we can contact if needed)			
Ethnicity			
Country of Birth			

Reminder Systems:

Our practice provides our patients with preventive care and early case detection reminders, e.g. immunisations, annual health checks, breast checks and pap smears.

Do you wish to have any relevant health reminders sent to you?

Yes No

If we need to contact you what is your preferred method of contact:

Phone Mail

Can we text reminders for appointments on your mobile phone?

Yes No

DUNSTAN DENTAL & MEDICAL SUITES
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ALLERGIES

Do you have any allergies or are you sensitive to drugs or dressings:

Yes (If yes please list below) No

Immunisations - Have you had the following immunisations?

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 is their immunisations up to date?

Yes No

Current Medications (including over the counter medications, vitamins and minerals)

Family History - Please list if there are any health problems for each family member:

1. Mother - is she alive? **YES / NO**

Please list any health issues: _____

2. Father - is he alive? **YES / NO**

Please list any health issues: _____

3. Brothers: _____

4. Sisters: _____

5. Grandparents [maternal and paternal]:

Maternal: _____

Paternal: _____

Social History

Tobacco: _____ day / week or Ceased Smoking - date _____

Alcohol: _____ day / week / month (circle the one applicable)

Drug use [past/present] _____ (type and frequency)

Height: _____ cms

Weight: _____ kgs

Year of last PAP smear & result of that smear [women]:
