NURIOOTPA MEDICAL CENTRE

6 Memorial Avenue, Nuriootpa SA 5355
Telephone 8562 2444 Fax 8562 3444
Email: manager@nuridocs.com.au

Appointments can be made on line at www.healthengine.com.au and download the app

NEW PATIENT INFORMATION FORM

☐Mr ☐Mrs ☐ Miss ☐ Ms ☐ Master ☐ Dr

Patient Surname: _____ First Name: _____

Date of Birth: ___ /__ /____ Age: _____ Preferred Name: _____

if under 18 must provide a- parent's details for billing purposes *

**Parents Name _____ Parent Date of Birth ____/____/_____

Patient Residential Address: _____
_____

Patient Postal Address: _____

_____

Patient Phone Number: (Home) _____ (Work) _____
Mobile: _____ Email: _____

*We ***send free sms appointment reminders*** please tick if you **don't** wish to receive reminder ☐

Interpreter required for the appointment……..

Your **CULTURAL IDENTITY** to assist with Health Initiatives **(please specify)**

☐ **ABORIGINAL** ☐ **TORRES STRAIT ISLANDER** ☐ **OTHER** _____

MEDICARE NUMBER

☐☐☐☐☐☐☐☐☐☐ **Ref #** ☐ expiry: ___/___/_____

CONCESSION CARD (PENSION or HEALTH CARE CARD) - (please CIRCLE WHICH ONE)

☐☐☐☐☐☐☐☐☐☐☐☐☐ Expiry: ___/ ___/_____

DVA CARD

☐☐☐☐☐☐☐☐☐☐ White/gold card expiry: ___/ ___/____ **P.T.O.**

PRIVATE HEALTH INSURANCE

Fund Name: _____ **Policy Number**: _____

NEXT OF KIN: (Name) _____

Relationship to you: _____

Contact phone Number (Home) _____ (Mobile) _____

EMERGENCY CONTACT PERSON: (Name)

_____

Relationship to you: _____

Contact phone Number (Home) _____ (Mobile) _____

I GIVE PERMISSSION FOR (Name) _____
TO COLLECT MEDICAL INFORMATION ON MY BEHALF

Relationship to you: _____

Personal Medical History

Allergies YES / NO

If YES, what Allergies do you have

What effect Mild/Moderated/Severe ……

What operations have you had?

1…… 3……..

2…… 4……..

Medication you are currently taking

1…… 3……..

2…… 4…….

Height Weight

☐ ☐

Do you smoke ?

Yes☐ No☐How many per day☐ Year commenced……..

Do you drink Alcohol? Yes☐ No☐How many per day(on average) ☐ did you previously drink……

☐ I have read and understood the above information regarding my medical information

Patient Signature _____ Date: ____/ _____/_____

ALL ACCOUNTS ARE TO BE SETTLED ON THE DAY OF CONSULTATION

It is important that all your information is up to date and correct
Please return <u>FULLY COMPLETED FORM</u> to our Receptionist.

Thank You for your co-operation.