

## BLI BLI CLINIC

### NEW PATIENT DETAILS FORM

Title: \_\_\_\_\_ Family Name: \_\_\_\_\_ Given Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

**The following information will assist us in the planning and provision of the best possible care.**

Are you of Aboriginal or Torres Strait origin?

No                       Yes, Aboriginal                       Yes, Torres Strait Islander                       Both Aboriginal & Torres Strait Islander

Are you from another cultural background?                       No                       Yes: \_\_\_\_\_

Is English your first language?                       No                       Yes

If English is not your first language, do you require an interpreter?                       No                       Yes

Street Address: \_\_\_\_\_

Suburb: \_\_\_\_\_ Post Code: \_\_\_\_\_

Home Phone No: \_\_\_\_\_ Work Phone No: \_\_\_\_\_ Mobile Phone No: \_\_\_\_\_

Medicare Card No: \_\_\_\_\_ Ref: \_\_\_\_\_ Expiry Date: \_\_\_\_\_

Health Care Card    **OR**    Pension Card No: \_\_\_\_\_ Expiry Date: \_\_\_\_\_

DVA Card No: \_\_\_\_\_ Expiry Date: \_\_\_\_\_                       Gold                       White

Occupation: \_\_\_\_\_

Next of Kin: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone No: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone No: \_\_\_\_\_

Do you have any known allergies?                       No                       Yes: \_\_\_\_\_

Have you ever/currently smoked?                       No                       Yes    How many per day/week? \_\_\_\_\_

Do you ever drink alcohol?                       No                       Yes    How many per day/week? \_\_\_\_\_

Please list any medications and dosage that you are currently taking:

\_\_\_\_\_  
\_\_\_\_\_

Do you have any significant family history?

Cancer    Family Member \_\_\_\_\_                       Blood Pressure    Family Member \_\_\_\_\_

Diabetes    Family Member \_\_\_\_\_                       Heart Disease    Family Member \_\_\_\_\_

Do you have any significant past medical history?

\_\_\_\_\_  
\_\_\_\_\_                      Height: \_\_\_\_\_                      Weight: \_\_\_\_\_

What recreational activities do you participate in? \_\_\_\_\_ Elite Athlete? \_\_\_\_\_

Accommodation:                       Own Home                       Nursing Home                       Other: \_\_\_\_\_

Live with:                       Alone                       Spouse                       Relative                       Friend

**Privacy Statement:**

We value your privacy. All information about you is kept in the strictest confidence and we operate in accordance with the *Privacy Act (1988)* and *Privacy Amendment (Enhancing Privacy Protection) Act 2012*. We are committed to protecting your privacy and ask for your consent for the use and disclosure of your personal health information as required during your health care.

I CONSENT TO THE USE AND DISCLOSURE OF MY PERSONAL HEALTH INFORMATION AS REQUIRED FOR MY HEALTH CARE

I CONSENT TO THE CLINIC REGISTERING ME FOR "MY HEALTH RECORD" AND UPLOADING RELEVANT INFORMATION

Signature: \_\_\_\_\_ Date: \_\_\_\_\_