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:_____