pirie medical centre
45 Gertrude Street
Port Pirie SA 5540
Ph: (08) 8633 2544
Fax: (08) 8633 1344

NEW PATIENT FORM

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other (please specify)……..	
First Name:	**Surname:**
Preferred Name:	**Date of Birth:**
Gender (please circle): Male / Female / Other……..	

Contact Details:

Street Address:		
Suburb:	**State:**	**Postcode:**
Postal Address (if different from above):		
Suburb:	**State:**	**Postcode:**
By providing us with the phone numbers below, you agree to the practice staff to leave messages identifying the practice as the caller.		
Home:	**Work:**	**Mobile:**
I consent to receive SMS for reminders, recalls, results and other SMS messages: YES / NO		

Other Information:

Marital Status:	**Occupation:**
Country of Birth:	
Do you need an Interpreter? YES / NO	**Language:**
To assist with health initiatives, are you Aboriginal or Torres Strait Islander? ☐ No ☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal & Torres Strait Islander	
Please state other cultural background:	

Do you have any of the following cards?
☐ Medicare ☐ Health Care Card ☐ Pension Card ☐ Veterans Affairs
Please note: you must present the above cards to reception, they must be in date and valid to receive any rebates or concessions including bulk bill services.

Next of Kin	**Name:**	
Relationship:	**Phone:**	**Male / Female**
Emergency Contact: (If different to Next of Kin)	**Name:**	
Relationship:	**Phone:**	**Male / Female**
Please provide the reception staff a copy of your legal power of attorney documents.		

By signing this form, I understand and acknowledge:

- Fees charged by Port Pirie Medical Centre (PPMC) are only related to services provided by the practice.
- I consent to PPMC checking Medicare Item Eligibility online through Services SA (HPOS)
- I will be personally responsible for the payment of non-attendance fees should I fail to attend an appointment or to give reasonable hours' notice when cancelling an appointment.
- I understand that whilst PPMC makes every effort to send SMS appointment reminders, non-receipt of an SMS reminder is not a valid reason for non-attendance scheduled appointment
- I am responsible for notifying PPMC when there is a change in my contact details

Signature:	**Date:**

PATIENT HEALTH DETAILS:

All information will be kept confidential

Your Medical History – Do you have or have you had history of?

Past operations/surgeries:

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

☐ **Asthma** ☐ **Diabetes** ☐ **Heart Disease** ☐ **Stroke**

☐ **High Blood Pressure** ☐ **Pace Maker** ☐ **Cancer:** Type: _____

☐ **Mental Health** ☐ **Other:** Please specify:_____

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

Allergies:

Do you have any allergies or are you sensitive to any medications or dressings? If so, what reaction have you experienced?

Allergy:	**Reaction Experienced:**

Advanced Care Directive:

Do you have an Advanced Care Directive for end of life care? Please circle: YES **/** NO
Please provide a copy to reception staff for your file. If you wish to
Know more about ACD's, please ask your GP or speak to a Nurse.

Immunisations:

Did you receive the scheduled/recommended vaccinations as a child and in high school? Please circle: YES/ NO

When was the last time you received a vaccination for the following:

Vaccination:	**Date:**	**Unsure / Never**
COVID Vaccination		Unsure / Never
Flu Vaccination		Unsure / Never
Pneumonia (over 65 years or over)		Unsure / Never
HPV (Gardisal)		Unsure / Never
Tetanus		Unsure / Never
Whooping Cough		Unsure / Never

Family History:

Have any members of your family had the following?

Medical Condition:	Family Member:
Diabetes	
Asthma	
Heart Disease	
High Blood Pressure	
Mental Illness	
Cancer	

Social History:

Have you ever smoked?	**Yes**	**No**	
Are you a current smoker?	**Yes**	**No**	
Do you drink alcohol?	**Yes**	**No**	**If yes, Frequency?** _____
Are you a drug user?	**Yes**	**No**	

When was your last:			
Blood Pressure Check?	**Within 12 months**	**1-2 years ago**	**unsure**
Blood Test for Cholesterol	**Within 12 months**	**1-2 years ago**	**unsure**
Weight/BMI Check?	**Within 12 months**	**1-2 years ago**	**unsure**

Females:

When did you last have:

Cervical Screening Test (Pap Smear):	**Date:**_____	**unsure / never**
Breast Check:	**Date:**_____	**unsure / never**

Males:

When did you last have:

Prostate Check?	**Within 12 months**	**1-2 years ago**	**3-5 years ago**	**never**

Patient Privacy:

The personal health information that you provide during your consultation and subsequent treatment will be used for the purposes of providing you with high quality health care. PPMC policy is to protect your privacy. The information you provide will only be disclosed to other members of our multi-disciplinary team at PPMC, this includes our doctors and practice nurses. Your information will be disclosed to other organisations when required by law. Your contact details may be disclosed for billing or debt recovery purposes.

A copy of our full **Patient Privacy Policy** is available on our website or at reception. If you have any concerns about the way we manage your health information, please let us know. In the first instance this can be done by contacting the Practice Manager or your GP. If you are still dissatisfied, you can contact the Federal Privacy Commissioner at:-

Office of the Australian Information Commissioner (OAIC) Website www.oaic.gov.au
GPO BOX 5218 Sydney NSW 2001 Privacy Hotline 1300 363 922

Signature:	**Date:**