

New Patient Details

Please fill out this form prior to your first consultation. All new patients are booked for a long appointment, which allows your doctor to take a thorough history and work through your health concern.

Your Privacy. We take the privacy of your personal information very seriously. We are collecting this information in order to provide you with high quality health services. We understand the personal and sensitive nature of the information you are providing to us and will safeguard your privacy in strict accordance with the Privacy Act (1988). If you would like to obtain a copy of our privacy policy or have any questions or concerns, please see our reception staff or our Practice Manager.

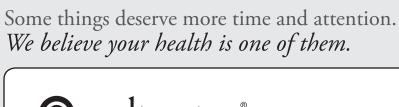
DRUGS OF ADDICTION PRESCRIBING POLICY: The Doctors at Saltwater Medical will not prescribe Drugs of Addiction or Schedule 8 Drugs to new patients at their first appoinment.

SECTION 1 PERSONA	Postal Address	Jse Residential Ac	ddress		
Title Family Name / Surn	name				
Given Name	Middle Name		State	Postcode	
Preferred Name	Date of Birth	Medicare Number	V	alid To	Ref.
	/ /			/	Position #
Gender		Do you hold a curren	nt Healthcare Ca	rd or Pension	er Card?
Male Female C	Centrelink Health	Centrelink Healthcare Card (tick)			
Ethnicity (please tick)		Centrelink Healthcare Card Number Expiry Da		е	
Non-Indigenous/Australian Aboriginal				/	
Torres Strait Island Aboriginal/Torres Strait Island Pensioner Card (tick)					
Other		Pensioner Card Numb	er	Expiry Date	e
Residential Address				/	
		Your Occupation			
		Usual / preferred Do	ctor		
State Postcode		Dr Nicola Kettleton-Butler Dr Cass Wys Dr Thanu Shekar Dr Rick Allen			
Home Phone	Work Phone	Next of Kin (Emergen	cy Contact)		
		, 5	,		
Mobile Phone	Preferred Contact Phone	Relationship to Patien	t Phone	e	
Email Address					1.
	How did you hear about us? (Please tick all that apply) Previous patient of the doctor at different medical centre				
		Newspaper Ad			ai centre
OFFICE USE ONLY:		Newspaper Ad Drive / walk past Radio Ad Leaflets in mail box			
☐ Untick Inactive Box ☐ Usual Dr, visit type & account		Online Search Local Pharmacy			
☐ Medicare Eligibility Check performed ☐ Tick SMS Box		Facebook / Instagram Word of mouth			
DATA INPUT BY:	DATE: / /			THOULIT	
		Other (please spe	cify)		

Patient Name:					
SECTION 2 SOCIAL & MEDICAL HISTORY					
What is your height? cms What is your weight? kgs					
Marital Status Single Married De-facto Widowed Separated					
Accommodation Home Owner Rental Relatives Home Nursing Home Homeless Other					
Live with Spouse Alone Relative/Parents Friend Other					
Do you have a carer? Yes No Name & phone of carer:					
Please list any operations or previous illnesses					
Current Medications Allergies Complementary Medications (e.g. Multivitamins, fish oil)					
Do you smoke? Yes No If yes, how many cigarettes do you smoke per day? Year started?					
Past smoking history Nil Light Moderate Heavy Year stopped smoking					
Do you drink alcohol? Yes No					
If yes, how many standard drinks per day? How many days per week?					
Family History Unknown (e.g. Adopted) No significant family history					
Mother Still Alive Yes No If no, age at death Cause of death					
Diabetes High Blood Pressure Heart Attack Stroke Colon Cancer Depression					
Breast Cancer Other (please specify)					
Father Still Alive Yes No If no, age at death Cause of death					
Diabetes High Blood Pressure Heart Attack Stroke Colon Cancer Depression					
Prostate Cancer Other (please specify)					
Female Patients Are you pregnant? Yes No Have you had a pap smear? Yes No Month/Year					

Are you breast feeding? Yes No Have you ever had a mammogram? Yes No Month/Year

Patient Name	e:
Other imme	ediate family member's significant illness (please specify)
Is there anyt	thing else you would like us to know about you?
SECTIO	NON-ATTENDANCE, LATE CANCELLATION & PROMPT ATTENDANCE POLICY
you. If you cancellated other pare rebatable	pride in delivering high quality healthcare, so your appointment time is booked and held especially for ou no longer require it, or cannot attend, please provide at least four business hours' notice of your ation. We are usually fully booked, so giving four hours' notice allows us to offer the appointment to tients. Unfortunately, failure to attend or notify us within the required timeframe may incur a non-medicare a fee (\$82 for a standard appointment, \$146 for a long appointment). Repeated late or non-attendance or result in the inability to book further appointments.
appreci	e ourselves on running on time (barring medical emergencies), so your punctuality is also ated. If you arrive unreasonably late for your appointment, you may need to reschedule and a non-ince fee may also apply.
Plea	ase tick here to indicate your understanding and acceptance of the policy outlined above.
SECTION	5 CONSENT
	t to the use of my personal health information by Saltwater Medical and other health care providers involved in my medical and healthcare within this medical centre.
 I consent or indired 	t to the disclosure of my personal health information by Saltwater Medical to other health care providers involved directly in my personal health care or medical treatment.
 I consent phone nu 	t to receive follow-up reminders and recalls to be sent to the address listed on this form and/or via SMS to my mobile umber.
	t to Saltwater Medical providing de-identified statistical health information relating to me/my child for the purposes of and quality assurance activities. Please be assured that your personal details such as name, address and date of birth a closed.
this prac	ad the information above and understand the reasons why my personal information is being collected. I understand tice has a privacy policy on handling patients information and that I am not obliged to provide any of the information d, but that failure to do so might compromise the quality of healthcare and treatment provided to me.
	are of my right to access the information collected about me, except in some circumstances where access might ely be withheld. I understand I will be given an explanation in these circumstances.
Signature	Date / /





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Care Experienc