New Patient Details

saltwater® MEDICAL
TRUST US TO CARE

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.

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

SECTION 1 | PERSONAL DETAILS

Title

Family Name / Surname

Given Name

Middle Name

Preferred Name

Date of Birth / /

Gender
○ Male ○ Female ○ Other

Ethnicity (please tick)
○ Non-Indigenous/Australian ○ Aboriginal
○ Torres Strait Island ○ Aboriginal/Torres Strait Island
○ Other

Residential Address

State Postcode

Home Phone

Work Phone

Mobile Phone

Preferred Contact Phone

Email Address

Postal Address ○ Use Residential Address

State Postcode

Medicare Number **Valid To** / **Ref.** Position #

Do you hold a current Healthcare Card or Pension Card?
○ Centrelink Healthcare Card ○ Pension Card

Healthcare or Pension Card Number

Expiry Date /

Your Occupation

Usual / preferred Doctor
○ Dr Nicola Kettleton-Butler ○ Dr Cass Wys
○ Dr Thanu Shekar ○ Dr Rick Allen ○ Dr Lisa Pinel

Next of Kin (Emergency Contact)

Relationship to Patient

Phone

How did you hear about us? (Please tick all that apply)
○ Previous patient of the doctor at different medical centre
○ Newspaper Ad ○ Drive / walk past
○ Radio Ad ○ Leaflets in mail box
○ Online Search ○ Local Pharmacy
○ Facebook / Instagram ○ Word of mouth
○ Other (please specify)

SECTION 2 | NON-ATTENDANCE, LATE CANCELLATION & PUNCTUALITY POLICY

We take pride in delivering high quality healthcare which means that your appointment time is booked and held especially for you. If you need to cancel **please provide at least four business hours' notice.** Giving four hours' notice allows us the courtesy of being able to offer your appointment to other patients on the waiting list, as we are usually fully booked each day. We confirm all appointments 24 hours before via telephone call. Failure to attend your appointment or notify us within the required timeframe may incur a fee ($85 for a standard appointment or $148 for a long appointment with no Medicare rebate available). Repeated late or non-attendance may result in the inability to book further appointments for a patient or family group. **We generally run on time (barring medical emergencies), so your punctuality is also appreciated.** If you arrive unreasonably late for your appointment, you may need to reschedule your appointment and a non-attendance fee may also apply.

Please sign here to indicate your understanding and acceptance of the policy outlined above.

Signature **Date** / /

OFFICE USE ONLY:
☐ Signed page 1 & 3 ☐ Ethnicity entered ☐ Usual Dr entered
☐ Visit type & acct entered ☐ Medicare Check ☐ SMS Box
DATA INPUT BY: ..... DATE: / /

Patient Name: _____

SECTION 3 | 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: _____

Other immediate family member's significant illnesses (please specify)

Is there anything else you would like us to know about you?

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.

SECTION 4 | CONSENT

- I consent to the use of my personal health information by Saltwater Medical and other health care providers involved in my medical treatment and healthcare within this medical centre.
- I consent to the disclosure of my personal health information by Saltwater Medical to other health care providers involved directly or indirectly in my personal health care or medical treatment.
- I consent to receive follow-up reminders and recalls to be sent to the address listed on this form and/or via SMS to my mobile phone number.
- I consent to Saltwater Medical providing de-identified statistical health information relating to me/my child for the purposes of research and quality assurance activities. Please be assured that your personal details such as name, address and date of birth are NOT disclosed.
- I have read the information above and understand the reasons why my personal information is being collected. I understand this practice has a privacy policy on handling patients information and that I am not obliged to provide any of the information requested, but that failure to do so might compromise the quality of healthcare and treatment provided to me.
- I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.

Signature _____ **Date** / /

Some things deserve more time and attention.
We believe your health is one of them.

saltwater® MEDICAL
TRUST US TO CARE

7 Fourth Avenue Caloundra QLD 4551
T (07) 5301 9828 F (07) 5329 4604
www.saltwatermedical.com.au

Time Care Experience