OCEAN WAVE MEDICAL
Excellence in Family Medicine

OCEAN WAVE MEDICAL PATIENT INFORMATION

This information is private and confidential
(please return this page to reception on completion)
Doc: CEN005 updated January 2017

SURNAME:___________________________ FIRST NAME:____________________ MIDDLE NAME:_______________

TITLE: Mr/Mrs/Miss/Ms/Dr DATE OF BIRTH:______________________________

SEX: Male/Female MARITAL STATUS: Single/Married/Widowed/Divorced/Separated

Country of Birth______________________ Do you identify as Aboriginal and/or Torres Strait Islander? Pls circle

NCACCH number_______________(if applicable)

Residential Address:____

Postal Address (if different to home):____

Email address :______________________________________

Phone: _____________________ Mobile: _________________________ Work:_________________________

MEDICARE NUMBER:______________________________REF NO:______________ EXPIRY:___________

PRIVATE HEALTH FUND NAME:_____________________ NUMBER:____________ EXPIRY:___________

PENSION or HEALTH CARD (please circle) NUMBER:__________________________ EXPIRY:___________

VET AFFAIRS CARD NUMBER (DVA):_______________________________________ EXPIRY:___________

(Please circle) Gold White Lilac Orange

RELIGION: (if applicable)______________________ OCCUPATION:____

Next of Kin:____ Relationship:____________________________

Phone: _____________________ Mobile: _________________________ Work:_________________________

Emergency Contact Name: __________________________Relationship:__________________________________

Phone: _____________________ Mobile: _________________________ Work:_________________________

It is recommended that your Emergency Contact should be separate person to your Next of Kin

How did you find out about our surgery? (please circle)

Word of Mouth	Drive/walk past	Facebook	Website	Holiday/Accom
Yellow Pages	Newspaper	Pharmacy	Relative	Internet search

If you wish to Transfer your Medical Records to us please complete form at Reception.

COLLECTION OF PERSONAL INFORMATION: Our practice will collect your personal information:
1.When you make your first appointment our practice staff will collect your personal and demographic information via your registration. 2.During the course of providing medical services, we may collect further personal information. 3. We may also collect your personal information when you visit our website, send us an email or SMS, telephone us, make an online appointment or communicate with us using social media. 4. In some circumstances personal information may also be collected from other sources. Often this is because it is not practical or reasonable to collect it from you directly. This may include information from: your guardian or responsible person. Other involved healthcare providers, such as specialists, allied health professionals, hospitals, community health services and pathology and diagnostic imaging services and your health fund, Medicare, or the Department of Veteran's Affairs (as necessary). DOC CEN 161 - KEEPING YOUR PERSONAL INFORMATION PRIVATE IN OUR PRACTICE is available for you at Reception.

By becoming a patient of Ocean Wave Medical and signing this form I agree and Consent to:
The collection of my personal information. Receiving recalls and reminders for preventative health plus appointment reminders via sms and/or post.

SIGNATURE OF PATIENT OR GUARDIAN:______________________ **DATE:__________________**

OEAN WAVE MEDICAL - NEW PATIENT REGISTRATION
Page 2 - CLINICAL INFORMATION

PATIENT NAME:___________________________________ DOB:___________________________
(This information will be entered into your Clinical Chart by our Practice Nurses and Doctor)

MEDICAL INFORMATION: (please circle or fill in your response)

Do you have any known allergies?	No Yes
If Yes List of known Allergies	
List your current Medications	
Do you Smoke?	No Yes If yes how many per day?
Past Smoking History	Which year did you stop smoking?
Alcohol consumption – do you drink alcohol **Past Alcohol consumption**	No Yes If yes how many drinks per day? How many days per week? Nil Light Moderate Heavy
PATIENT HISTORY (Please circle the most appropriate answer fill out all other areas)	
DIABETES ASTHMA HIGH BLOOD PRESSURE HEART PROBLEMS	
DEPRESSION STROKE KIDNEY DISEASE BREAST CANCER	
EPILEPSY COLON CANCER OTHER CANCERS:	
Do you know your Blood Group?	No Yes If Yes what group are you?
Previous Medical Practice Attended: Plans or Health Assessment in last 12mths	 Type of plan:
Female Patients – Date of last pap smear	
FAMILY HISTORY	Unknown (adopted) No significant history (circle below)
Mother - still alive Mother history of (please circle)	Yes or No If no age of Death: Diabetes Kidney Disease Asthma High Blood Pressure Heart Disease Breast Cancer Colon Cancer Stroke Depression Epilepsy Other Cancers:
Father - still alive Father history of (please circle)	Yes or No If no age of Death: Diabetes Kidney Disease Asthma High Blood Pressure Heart Disease Breast Cancer Colon Cancer Stroke Depression Epilepsy Other Cancers:
Other immediate family members significant illnesses:	Please list
Children	Please provide copy of child's immunisation history