New Patient Questionnaire

Title: ☐ Miss ☐ Ms ☐ Mrs ☐ Mr ☐ Mx

First Name: …… **Last Name:** ……

Preferred Name: …… *If different*

Gender: ☐ F ☐ M ☐Other **Date of Birth:** DD/MM/YYYY

Home Address: ……

Suburb: …… **Postcode:** ……

Mobile: ……

Email: ……

Medicare No: |___|___|___|___| |___|___|___|___|___| |___| **Ref. No:** |___| **Exp:** MM/YYYY

It is important that we have some information about your cultural background in order to provide appropriate care.

What is your country of birth? ……

Do you identify as Aboriginal and/or Torres Strait Islander?

☐ No ☐ Yes - Aboriginal ☐ Yes - Torres Strait Islander ☐ Yes - Aboriginal & Torres Strait Islander

Emergency Contact: *In the event of an emergency, please provide details of whom we should contact.*

Name:…… Phone:……Relationship:……

Next of Kin: *If different from above.*

Name:…… Phone:…… Relationship:……

Under 16s only – Parent / Guardian details

First Name: …… Last Name: …… DOB: DD/MM/YYYY

Medicare No: |___|___|___|___| |___|___|___|___|___| |___| Ref. No: |___| Exp: MM/YYYY

Do you have any allergies or sensitivities?

☐ No ☐ Yes …… (If so, what happens?.....)

Do you smoke? ☐ Never ☐ Stopped in YYYY ☐ Yes …… per day

Do you drink alcohol? ☐ Never ☐ Stopped in YYYY ☐ Yes …… units per day

Do any of your family members currently attend Turn The Corner Medical Clinic?

1. …… Relationship to you: ……

2. …… Relationship to you: ……

3. …… Relationship to you: ……

Communication from Turn the Corner

We send appointment reminders and secure links to certain test results via SMS. We operate a recall system for matters of clinical significance. We participate in a personalised reminder program for preventive health issues such as skin checks and annual health assessments. We also produce an e-newsletter every month or so with Clinic information and relevant general health information for our clients.

Please indicate whether you consent to receive the e-newsletter. ☐ No ☐ Yes

Finally – your agreement

"I have read and agree to the Clinic's Terms and Privacy policy (available on the website), and agree to pay the fees associated with the services I receive or ask to receive from Turn The Corner Medical Clinic".

Signature:……. Date: DD/MM/YYYY

of Patient, or of parent/guardian if Patient is less than 16 years of age.

Thank you. Please return this form to Reception - reception@turnthecorner.com.au