New Patient Questionnaire

Title: ☐ Miss ☐ Ms ☐ Mrs ☐ Mr ☐ Mx

First Name: …….. **Last Name:** …….

Preferred Name: …… *If different*

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

Gender Identity: ☐ F ☐ M ☐ Non-binary ☐ Gender diverse ☐ Transgender ☐ Different identity

Pronouns: ☐ She/Her/Hers ☐ He/Him/His ☐ They/Them/Theirs

Mobile: ……

Email: ……

Home Address: ……

Suburb: …… **Postcode:** ……

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

Private health insurance: *If applicable.* **Name of insurer:** ……

Pension Card details: *If applicable.*

Card type: ☐ Pensioner Concession Card ☐ Health Care Card ☐ Commonwealth Seniors Health Card

Number: …….. **Expiry Date:** DD/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:……

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

Did a family member or friend recommend Turn The Corner to you? ☐ No ☐ Yes

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

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 operate a personalised reminder system for preventive health issues. We distribute a monthly e-newsletter with Clinic information and relevant general health information; each e-newsletter provides an opt-out option.

And finally – your agreement

"I have read and agree to the Clinic's website terms and conditions; its privacy policy (also published on turnthecorner.com.au); and its communication policy (above). I agree to pay the fees associated with the services I receive or ask to receive from Turn The Corner".

Signature:…… Date: DD/MM/YYYY

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

Under 16s only – Parent / Guardian details

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

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

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