FIRST PEOPLES'
HEALTH AND WELLBEING

please return this form to thomastown@fphw.org.au
or hand to our friendly reception team

First Peoples' Health and Wellbeing

New patient form - under 10 years old

To become a patient at First Peoples' Health and Wellbeing, we require your agreement for us to collect personal information. This is to make sure we can provide you with quality health care. We need you to provide this information so that we can properly assess, diagnose and treat your health conditions, as well as be aware of your possible health risks.

First Peoples' Health and Wellbeing will always look after your personal information in a way that protects your privacy and adheres to the National Privacy Principles and the Victorian Health Records Act. You may request a copy of our privacy policy at any time.

Please read this carefully, tick the boxes and sign below, or speak to one of our health clinic team.

☐ I give my permission for my personal health information to:

be used to assist in the running of First Peoples' Health and Wellbeing
be shared when required with relevant individuals involved in my healthcare
be used in a way that does not personally identify me in reports for organisations that provide funding to First Peoples' Health and Wellbeing
contact me about my health and remind me about appointments
comply with any laws or regulation requirements e.g. notifiable diseases
be added to national and state reminder systems including cancer screening and immunisations

OR

☐ I am unsure and would like to speak to someone in the health clinic

Signed: _____ Date _____

First Peoples' Health and Wellbeing

New patient form | confidential

Your details

First name | Middle name | Last name

Preferred name | Date of Birth | Age

Sex: Female | Male | Intersex

Gender: Female | Male | Other

Are you: Aboriginal | Torres Strait Islander | Aboriginal **and** Torres Strait Islander | Non-Indigenous

Who's your mob?

Do you go to school? | Which school?

Card details

Name on Medicare card

Medicare number | Ref | Expiry

Pensioner / Health Care Card number | Ref | Expiry

Do you have ambulance cover? Yes | No

Do you have private health cover? Yes | No

Name of private health fund | Member number

Contact details

I understand it is my responsibility to update First Peoples' Health and Wellbeing with my correct contact details

Home Address

Mailing address

Mobile number

Home number

Email address

Communication consent

- Agree to receive SMS messages about appointments
- Agree to receive SMS messages about news and events
- Agree to receive email newsletter

Emergency contact details

I understand it is my responsibility to update First Peoples' Health and Wellbeing with my correct contact details

Next of kin contact name

Next of kin contact number

Next of kin relationship to you

How many other people live in your house?

Do you live with any pets? Yes ☐ No ☐ How many?

Medical records

Do you require your medical records to be transferred from another clinic? ☐

Doctors name

Name of clinic

Town of clinic

Previous medical history

Tell us about any medical conditions you have or have had

Current medications

Which medications do you take currently? Include over-the-counter and natural medicines

Measurements

Height

Weight

Waist measurement

Recent trips to hospital

What for

Year | Which hospital

What for

Year | Which hospital

What for

Year | Which hospital

Other health information

Allergies

Do you have any allergies or sensitivities?

To what? | What happens?

To what? | What happens?

To what? | What happens?

To what? | What happens?

To what? | What happens?

Family medical history

Please let us know the medical history of your close family members and who in your family has/had these conditions

I believe this is an accurate and true record of my current health situation

Name:

Signature

Parent ◯ Carer ◯ Other