**Brecken Health Mandurah**
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# New Patient Registration & Health Questionnaire

Brecken Mandurah
BUILT TO CARE

1. Patient details

**Title:** Mr / Mrs / Ms / Miss / Master / Dr / Other: _____ **Date of birth:** _____ / _____ / _____

**First name:** _____ **Surname:** _____

**Birth sex:** Female / Male / Other / Unknown **Gender identity:** Female / Male / Non-binary / Gender diverse / Transgender / Prefer not to say

**Pronouns:** she/her/hers he/him/his they/them/theirs Other: _____ **Occupation:** _____

**Residential address:** _____

**Suburb:** _____ **Postcode:** _____

**Mobile:** _____ **Home / work phone:** _____

**Email:** _____ **Country of birth:** _____

**Language spoken (if other than English):** _____ **Interpreter required?** YES / NO

**Are you of Aboriginal or Torres Strait Islander origin?** ☐ No ☐ Aboriginal ☐ Torres Strait Islander ☐ Both

## 2. Medicare, concession and insurance details

**Medicare card number:** _____ **Expiry:** _____

**Line number (next to your name):** _____ **Expiry:** _____

**Centrelink HCC / Pension card number:** _____ **Expiry:** _____

**DVA card number:** _____ **Expiry:** _____

**Private health insurance fund and number:** _____ _____

*Please note: new patients not registered with Medicare are required to supply photo identification on registration.*

## 3. Next of kin and emergency contact

**Next of kin** (☐ tick if also your emergency contact)

**Name:** _____ **Relationship to you:** _____

**Phone number:** _____ **Address (if different to yours):** _____

**Emergency contact (if different)**

**Name:** _____ **Relationship to you:** _____

**Phone number:** _____ **Alternate phone:** _____

## 4. Previous doctor and communication preferences

**Name of last doctor / surgery:** _____

**Do you consent to us requesting a copy of your health summary from your previous practice?** YES / NO

**Preferred contact:** Email / SMS / Letter / Phone **SMS appointment reminders:** YES / NO **Prescriptions:** Paper / Email token / SMS token

**How did you hear about us?** Word of mouth / Chemist / Corporate medical / Internet search / Radio / Signage / Emergency dept. / Television / Newspaper / Referral / Social media

## 5. Health questionnaire

**Full name:** _____ **Date of birth:** _____

**Medical history.** Any pre-existing conditions your doctor should know about (e.g. asthma, diabetes, epilepsy, cancer, heart disease, high blood pressure, mental health conditions), and any operations or hospital admissions with approximate years:

**Family history.** Health problems that run in your family (e.g. cancer of any type, heart disease, diabetes, stroke):

**Medication.** All current medicines, including over-the-counter, herbal and supplements (write "none" if not applicable):

**Allergies.** ☐ **I have no known allergies** (otherwise complete the table below)

| I am allergic to | Nature of reaction | Severity (mild / moderate / severe) |
|---|---|---|
| | | |
| | | |
| | | |

**I carry adrenaline (e.g. EpiPen):** YES / NO **I get hay fever, eczema or asthma:** YES / NO

**Smoking and alcohol. Smoking history:** Never smoked / Social / Ex-smoker / Current Number per day: _____ Year started: _____ Year quit: _____

**Do you vape?** YES / NO **Alcohol:** Never / _____ days per week Standard drinks on a typical drinking day: _____

**Immunisation and screening.** Last tetanus: _____ Last influenza: _____ Last COVID-19: _____ Children's immunisations up to date? YES / NO

**If applicable, date of last:** Cervical screening _____ Mammogram _____ Prostate check _____ Bowel screening (FOBT) _____ Cholesterol / glucose _____ Skin check _____

**Anything else you would like your doctor to know?**

## 6. Privacy, consent and use of AI

This practice complies with the Privacy Act 1988. Your personal information is collected to provide quality medical and health related services and associated account keeping, is managed in accordance with the Australian Privacy Principles, and you may request access to it or withdraw your consent at any time (except where legal obligations must be met).

**My signature below indicates that I consent to (cross out anything you do not agree to):** the practice collecting, using, storing and disposing of my personal information; the release of relevant information to other health professionals involved in my care (e.g. specialists, pathology, radiology, allied health); inclusion in a recall and reminder register; contact by electronic means including SMS, email and phone; the release of relevant information to my employer, their authorised representatives and their insurer for a work-related consultation; and the uploading of relevant clinical information to My Health Record unless I advise otherwise.

**Use of artificial intelligence (AI).** We use AI tools to help prepare consultation notes and to assist with administration such as letters, recalls and billing. All AI output is reviewed and approved by your doctor or a staff member, information is processed securely in Australia and is never used to train AI products, and AI is not used to make decisions about your care. Use of an AI scribe during your consultation is voluntary — you will be asked before it is used and can decline at any time without affecting your care.

**Use of an AI scribe during my consultations:** ☐ **I consent** ☐ **I do not consent** *(you may change this at any time)*

## 7. Fees and billing

**Please note: we are a private billing practice.** All accounts must be paid in full at the time of consultation. Where a Medicare rebate applies, we can process it on the day if your Medicare and bank details are registered with Services Australia; otherwise, Services Australia will pay your rebate directly. Current fees are displayed at reception and available on request, and a fee may apply for appointments cancelled with less than the required notice or not attended.

**I understand that all accounts must be paid at the time of consultation.** ☐ **Yes** **Have you read and understood the privacy policy and fee structure? YES / NO**

I confirm that the information I have provided in this form is true and correct to the best of my knowledge, and I consent to the matters set out above.

**Patient signature:** _____ **Date:** _____

*If signing on behalf of a patient:* Name _____ Relationship to patient _____

| | | |
|---|---|---|
| Office use: ID sighted ☐ Yes ☐ No | Medicare verified ☐ Yes ☐ No | Entered by / date: _____ |