• HEALTH AND WELLBEING •
WULGURU MEDICAL CENTRE
Ph: 4778 3355 | Fx: 4778 3420 | Em: reception@hwbw.com.au

New Patient Intake Form

Title: **Preferred Name:**

Surname: **Given Names:**

Date of Birth: **Country of Birth:** **Ethnicity:**

Interpreter required: Yes | No **Main Language:**

Cultural Background: ☐ **Aboriginal** | ☐ **Torres Strait Islander** | ☐ **Non-Indigenous**

Marital Status:
☐ **Single** | ☐ **Defacto** | ☐ **Engaged** | ☐ **Married** | ☐ **Separated** | ☐ **Divorced** | ☐ **Widowed**

Gender Identity:
I identify as ☐ **Male** | ☐ **Female** | ☐ **Transgender** | ☐ **Non-Binary** | ☐ **Different identity:**

Birth Gender: ☐ **Male** | ☐ **Female**

Pronouns: ☐ **She/her/hers** | ☐ **He/Him/His** | ☐ **They/Them/ They Are** | ☐ **Other:**

Residential Address				**Postal Address** (If Different)			
Address:				**Address:**			
Suburb:		**Post Code:**		**Suburb:**		**Post Code:**	

Home: **Work:** **Mobile:**

Email:

Medicare No: **Ref:** **Expiry:**

Concession Card No: **Type:** Pension / Health Care Card **Expiry:**

DVA Card: ☐ **White** | ☐ **Gold** **Conditions:**

Health Insurance Fund: ☐ **Yes** | ☐ **No** **Expiry:**

Fund Name: (If applicable) **Member Number:**

Do you consent to receiving SMS reminders? Y / N

We need Next of Kin or Emergency Contact details in case we are unable to get ahold of you. Let us know if you have no Next of Kin or an Emergency Contact.

Next Of Kin		**Emergency Contact** (different contact)	
Name:		Name:	
Address:		Address:	
Contact No:		Contact No:	
Relationship:		Relationship:	

CONSENT

We require your consent to collect personal information about you. Please read this information carefully and sign where indicated below.

We need this information to provide the best quality care. This form complies with RACPG *Standards for general practices.* This means that your personal Health information is kept private and secure, as required by Federal and State privacy laws. If you have any concerns, please leave blank and discuss with the Doctor.

Please notify us promptly of any changes in your contact details.

Accurate contact details help us identify you and your medical records and allow us to contact you promptly about tests and results.

This medical practice collects information from you for the purpose of providing equality in health care. During the consultation, your doctor may ask for your personal details and a full medical history so we may properly access, diagnose, treat and be proactive in your health care needs. This means we may use the information you provide in the following ways:

- Administrative purposes in running our medical practice
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements
- Disclosure to others involved in your healthcare, including treating Doctors and Specialists outside the medical practice. This may occur through referral to other Doctors, for pathology and x-ray, in the reports, or results returned to us following the referrals
- Disclosure to other Doctors in the practice, Locums, Registrars, or Medical students attached to the practice for the purpose of patient care and teaching. Please let us know if you do not want your records assessed for these purposes, and we will note this on your record accordingly.
- Disclosure to a medical legal defence organisation if a medico-legal issue arises
- Pap Smear registry
- Australian Childhood Immunisation Register
- Family cancer register

I have read the information above and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling patient information.

I understand and consent to Health and Wellbeing Wulguru uploading a shared health summary to My Health Records. If I do not consent, I will inform reception upon arrival before seeing any health practitioner.

I understand and consent to Health and Wellbeing Wulguru Practice Policies and Procedures.

I understand that I am not obliged to provide information requested of me, but my failure to do so may compromise the quality of health care and treatment given to me.

I am aware of my right to access information collected about me, except in some circumstances where access might be legitimately withheld. I understand that I will be given an explanation in those circumstances.

I understand that if my information is to be used for any other purposes other than those set out above, subject to any limitations, access, or disclosure, that I notify the practice.

I understand that if I fail to attend any booked appointment without contacting the practice more than twice, I may be charged a cancellation fee. This will be required to be paid at the time of the next consultation.

Patient Name: _____ DOB: __/__/_____ Guardian Name: _____

Patient or Guardian Signature: _____ Date: __/__/_____

Medicare card sighted by reception staff: ☐ **Yes** Reception Initial: _____

Document title: New Patient Intake Form
Reviewed by: Kea Jones / Practice Manager
Version 2.03 | Effective Date: 13.10.2025
Next Review Date: 08.08.2026

Do you have an Advance Health Directive and/or Enduring Power of Attorney?

A document that states your medical & health care treatment/directions. This comes into effect when you are unable to make your own decision.

☐ **Advance Health Directive |** ☐ **Enduring Power of Attorney**

Details:

Allergy Status:

Do you have any allergies? ☐ **Yes |** ☐ **No**

If yes, Specify:

Reaction:

Severity: ☐ Mild | ☐ Moderate | ☐ Severe

Medical History:

Height: **Weight:** **BMI:**

Do you have any regular medical conditions? T2DM, and what year were you diagnosed ☐ **Yes |** ☐ **No**

If yes, specify:

Are you on any over-the-counter and/or prescribed medications? ☐ **Yes |** ☐ **No**

If yes, specify:

Occupation

Current Occupation: ☐ **Unemployed |** ☐ **Prefer not to say**

Have you served within the Australian Defence Force: ☐ **Yes |** ☐ **No |** ☐ **Prefer not to say**

☐ **Army |** ☐ **Air Force |** ☐ **Navy |** ☐ **Army Reserves** **How many years?** (Optional)

Religious beliefs

Do you practice Religion? ☐ **Yes |** ☐ **No |** ☐ **Prefer not to say** **If yes, what religion:**

Alcohol Status

Do you consume Alcohol? ☐ **Yes |** ☐ **No |** ☐ **Not any more |** ☐ **Prefer not to say**

How often do you consume a drink that contains alcohol?

How many standard drinks do you consume on a typical day?

How often would you consume more than six (6) standard drinks?

Year started: **Year stopped:**

Smoking Status

Do you smoke cigarettes or tobacco? ☐ **Yes |** ☐ **No |** ☐ **Not any more |** ☐ **Prefer not to say**

Type: ☐ **Cigarette |** ☐ **Vape |** ☐ **Other**

How many do/did you smoke per day?

Year started: **Year stopped:**

***THIS PAGE IS TO BE DISTRIBUTED TO THE NURSE BY THE RECEPTION STAFF**

Patient name:

DOB: __/__/_____

Document title: New Patient Intake Form
Reviewed by: Kea Jones / Practice Manager
Version 2.03 | Effective Date: 13.10.2025
Next Review Date: 08.08.2026