PATIENT INFORMATION AND PAYMENT FORM

INTEGRATIVE G. P.

CENTRE FOR Health and Wellbeing

OFFICE USE ONLY
DOCTOR

PATIENT DETAILS

Mr Mast Mrs Miss Ms Dr Surname _____

Given names _____ Preferred name _____ DOB _____

Residential address _____

_____ Post Code _____

Mailing address _____ ***I have attended a*** DR K ***seminar*** ☐

Phone mobile _____ (Text reminder will be sent to this number) home _____ work _____

Email _____ Occupation _____

PLEASE SHOW YOUR MEDICARE AND CONCESSION CARDS TO THE RECEPTIONIST

Medicare number _____ Ref # _____ Expiry date _____

Pension card / Health care number _____ Expiry date _____

Veteran's Affairs Gold Card _____ Expiry date _____

Name of Next Of Kin (**NOK**) _____ Relationship of NOK _____ Phone _____

If you prefer not to elect NOK please tick the box ☐

Emergency contact name (if different) _____ Phone _____

PAYER DETAILS [i.e Parent/Guardian if patient is a child/dependent]

Mr Mrs Miss Ms Dr Surname _____ Given Names _____

DOB _____ Address _____

Phone _____ Email _____

Relationship to Patient _____

Medicare number _____ Ref # _____ Expiry Date _____

If WorkCover, Third Party or Insurance Claims please give details

Type of injury _____

Date of injury _____ Details of insurer: _____

Claim number (if applicable) _____ Claims manager _____

Phone _____ Employer's name & address (if applicable) _____

I, _____ understand that ……..

- Some of the diagnostic tests, treatments and products administered by practitioners at Centre for Health and Wellbeing, may be outside the perimeters of conventional medicine in Australia.
- These tests, treatments and products fall into the category of Natural or Complementary Medicine.
- These diagnostic tests, treatments and products are supported by empirical knowledge and in many cases by research data.
- That these tests, treatments and products are safe, are widely and successfully used by Integrative Medical Practitioners in centres in Australia and overseas, and are only prescribed with the utmost care.
- Some diagnostic test and treatments offered at Centre of Health and Wellbeing are **not** covered by Medicare or private health funds.
- All Centre for Health and Wellbeing Practitioners are members and active participants of their respective professional colleges.
- I understand the Centre for Health and Wellbeing practitioners may recommend and dispense items that are yet to be regulated by the "Therapeutic Goods Administration (TGA), should the practitioner deem that such products or treatments are in my best interest. If there are any risks associated with using unregulated products or treatments, the Centre for Health and Wellbeing practitioner (s) will make me fully aware of those risks and provide me with sufficient information to make an informed decision.

Patients are responsible for all account payments. If you are unable to attend an appointment we require at least 24 hours' notice. A late cancellation or non-attendance fee of $60-00 (30 minute consult) or $30-00 (15 minute consult) will apply. If you miss an appointment without notice, you will be charged the full fee. These fees are not claimable through Medicare

I am attending Centre for Health and Wellbeing of my own free will and consent and exercise my right to discuss and choose any useful and suitable treatment(s) make available to me. I am responsible for the full amount of fees. I declare that the above information to be true and correct.

Signed _____ Today's date _____

We accept Eftpos, Credit Card, Cheque or Cash (Not Amex or Diners)

QUESTIONNAIRE

CENTRE FOR Health and Wellbeing

Surname _____ Given name (s) _____ Today's date _____

MEDICAL HISTORY

Current health issues **please include sleep issues and any bowel issues* _____

Previous medical history. Please bring all the medical results you have from the last 6 months **please include any history of fractures, cardiovascular issues like palpitations, infertility issues*

Previous surgical history _____

Allergies and / or any sensitivities to particular foods, drugs or dressings _____

Medications / Supplements **please bring your medication and supplements with you to the consult* _____

Vaccinations _____

SOCIAL AND LIFESTYLE HISTORY

Alcohol ☐ non-drinker ☐ drinker ☐ monthly or less ☐ 2-4 per month ☐ 2-4 per week ☐ 4+ per week

Smoking ☐ never ☐ ceased smoking _year_ ☐ smoker #____ per day week

Vigorous activity ie: *running, swimming, aerobics, tennis, bike riding ☐ 1 day ☐ 2 days ☐ 3 days ☐ 4+days ☐ never

Activities ie: *meditation, yoga, gardening, swimming, dancing, other ☐ yes ☐ no

Marital status ☐ single ☐ married ☐ de facto

Occupation _____ Pets _____

Overseas holidays (within the last 12 months) _____

Surname _____ Given name (s) _____

FAMILY HISTORY (if known) **please include history of heart problems, thyroid issues, diabetes, cancers, high blood pressure, depression and anxiety, bone period and joint problems, pregnancy problems, other*

Mother _____

_____

Father _____

_____

Sister/s _____

_____

Brother/s _____

_____

Maternal Grandmother _____

Maternal Grandfather _____

Paternal Grandmother _____

Paternal Grandfather _____

Maternal or Paternal Aunts _____

Maternal or Paternal Uncles _____

Maternal or Paternal Children _____

FOR WOMEN ONLY

Date of last cervical screen _____	Number of children _____	Painful periods _____
Number of pregnancies _____	Post-natal depression _____	Heavy periods _____
Number of miscarriages _____	Age when first used pill _____	PMT _____
Last mammogram _____		

IS THERE ANY OTHER INFORMATION that you believe we should know that may affect or have an influence on the medical treatments / advise you will be provided with?

_____

_____

_____

_____

Please provide your main reasons for visiting us _____

_____

_____

Thank you! The information you have provided is Confidential and is valuable in guiding your medical care.