Alpine Health Centre®

40 Prince Street, Rosedale VIC 3847
4 Gippsland Street, Jindabyne NSW 2627
Ph: 1300 360 791 Email: info@alpinehc.au

Patient Details

To be completed by the Patient or Support Person.
Please print clearly in BLOCK letters.

PERSONAL

Family Name: | **Title:** | **DATE:**

Given Name(s) (as appears on Medicare Card):

Preferred Name: | **Date of Birth:** | **Current Age:**

Sex Assigned at Birth: ☐ Male ☐ Female | **Occupation:**

CULTURAL

Knowing your cultural background can help us provide health care that meets your individual needs.
Are you of Aboriginal or Torres Strait Islander origin?

☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, Aboriginal & Torres Strait Islander

Other cultural background (eg Mediterranean, Asian, African etc): | **Country of Birth:**

CONTACT DETAILS

Residential Address: | **State:** | **PC:**

Postal Address: | **State:** | **PC:**

Home Ph: ( ) **Mobile:** **Work Ph:** ( )

Email:

I consent to being contacted with reminders to help me maintain my health. ☐ Yes ☐ No

HEALTH COVER

Medicare Card Number: **Ref No.:** **Expiry:**

Pension / Health Care Card Number: **Expiry:**

Pension Card Type:

DVA Number: ☐ **Gold** ☐ **White** **Expiry:**

Private Health Cover:

NEXT OF KIN

Name: **Relationship:** ☐ Spouse ☐ Partner ☐ Parent ☐ Guardian ☐ Other

Address:

Home Ph: ( ) **Mobile:** **Email:**

Emergency Contact Name: **Contact Number:**

Medicare Card Number: **Ref No.:** **Expiry:**

CURRENT GP

Name: **Practice Name:**

Address:

Work Ph: ( ) **Fax:** ( ) **Mobile:**

Specialty: **Email:**

NDIS Details

Do you have a current NDIS Plan? ☐ Yes ☐ No NDIS Plan: *(Start date)*: *(End date)*:

NDIS Ref. No.: Are you: ☐ Agency-Managed (NDIA) ☐ Plan Managed ☐ Self-Managed

Co-ordinator of Services (Business name): Contact Person.:

Work Ph: ( ) Mobile: Email:

Plan Manager for Invoices (Business name): Work Ph: ( )

Email for Invoices:

Please return the completed form to the Alpine Health Centre® (AHC).

Allergies

ALLERGIES

List allergies and intolerances:	Describe your reaction:

Medication - Current medications (including weight loss medication, over-the-counter medications, vitamins and minerals etc.)

MEDICATION

Drug Name:	Strength:	Prescribed Dosage :	Reason:

Medical & Mental Health History - Do you have or have you had a hitory of any of the following?

MEDICAL & MENTAL HEALTH HISTORY

- ☐ Operations (Year & details):
- ☐ Injuries (Year & details):
- ☐ Cardiovascular history (details):
- ☐ Lung condition (details):
- ☐ Diabetes: ☐ Type 1 ☐ Type 2 ☐ Metabolic Syndrome ☐ Insulin resistance ☐ PCOS (details):
- ☐ Cancer (Year & details):
- ☐ Chronic pain (details & complete page 3):
- ☐ Muscular/skeletal (arthritis/muscle/joint pain):
- ☐ Chronic illness (Year diagnosed & details):
- ☐ Weight concerns: ☐ Under weight ☐ Over weight ☐ Do you want help with these concerns: ☐ Yes ☐ No
- ☐ Sleep disorder (details): ☐ Trouble going to sleep ☐ Broken sleep ☐ Insomnia ☐ Sleep apnoea
- ☐ Mental illness (details): ☐ Depression ☐ Anxiety ☐ OCD ☐ PTSD ☐ BPD ☐ ASD ☐ ADHD ☐ Other
- Have you trialled: ☐ Antidepressants ☐ Psychological / Counselling therapy ☐ Dialectical Behaviour Therapy (DBT)
- ☐ Eye Movement Desensitisation Reprocessing (EMDR) ☐ Transcranial Magnetic Stimulation (TMS) ☐ Clinical hypnotherapy
- Details:
- ☐ Are you on hormonal replacement therapy (HRT)? (Details):
- ☐ Do you currently smoke cigarettes / vapes *(cicle answer)*? How many per day: ..... Do you want to stop smoking? ☐ Yes ☐ No
- ☐ Do you currently drink alcohol? Standard drinks per day: ☐ 1-3 ☐ 4-7 ☐ 7+ Do you want to stop drinking? ☐ Yes ☐ No
- ☐ Other health concerns: ☐ Incontinence ☐ Premenstrual syndrome (PMS) ☐ PCOS ☐ Endrometriosis ☐ Skin condition
- ☐ Autoimmune disease ☐ (Other / details):

If you suffer from ACUTE or CHRONIC PAIN, please complete the following:

Pain is a patient-specific experience that requires ongoing assessment and evaluation, both by patients and their providers.

1. **Patient Information re acute or chronic pain**: **DATE:** ……

First Name: …… **Surname**: ……..

☐ First visit ☐ Follow-up visit Birth gender: ☐ Male ☐ Female

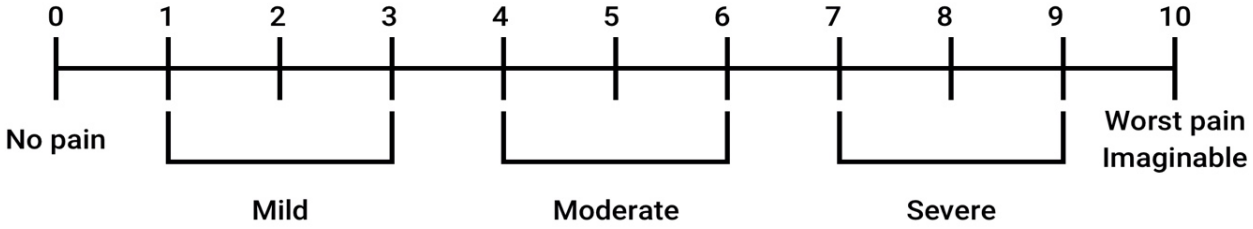
Age group: ☐ 1-14 ☐ 15-19 ☐ 20-29 ☐ 30-39 ☐ 40-49 ☐ 50-59 ☐ 60-69 ☐ 70+

Height: …… cm Weight: …… Kg BMI: …… ☐ Underweight ☐ Normal ☐ Overweight ☐ Obese I ☐ Obese II ☐ Obese III

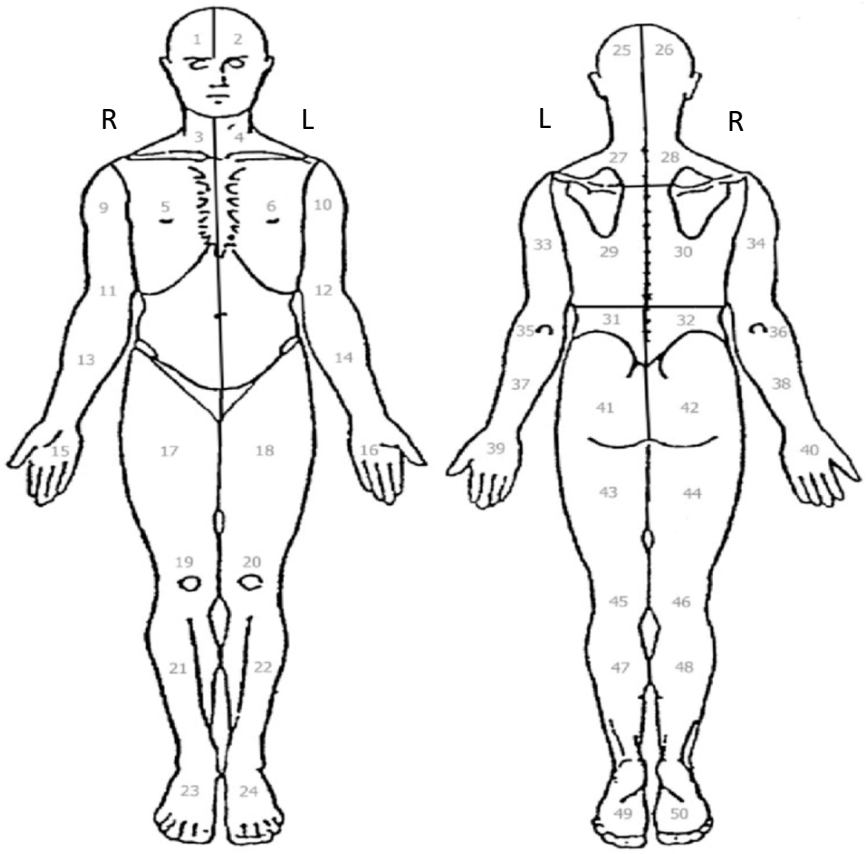
Waist Circumference: ……. cm Wrist Circumference: ……. cm Body frame size: ☐ Small ☐ Medium ☐ Large

2. **During the past week/s, have you had any pain?** ☐ No ☐ Yes

3. **During the past week, how would you rate your baseline pain on a scale of 0** (no pain) **to 10** (worst pain)**?**



4. Where do you feel this pain? (In the diagram below, shade in the areas where you experience this pain).



Comments:

Pain score today (0-10) = ……

Pain score post treatment (0-10) = ……

Health Information and Consent Form

As a patient of our healthcare practice, please provide your details and complete medical history so we can properly assess, treat, and proactively address your healthcare needs.

We aim to protect the privacy and secure storage of your health information. You can request a copy of our privacy policy, which details how we collect, use, and disclose your health information.

We require your consent to collect personal information about you and to use the information you provide in the following ways.

Please read this consent form carefully and sign it below.

Uses of your information:

- For administrative purposes in managing our practice.
- For billing, including compliance with Medicare and the Health Insurance Commission.
- To share information with others involved in your healthcare, such as treating doctors and specialists outside this practice. This may include referrals to other health providers, for medical tests, and through reports or results sent back to us following referrals.
- To disclose to other doctors in the practice, locums, and staff involved in your care and training.
- For research and quality assurance efforts aimed at enhancing individual and community health care and practice management. Anonymous information is used but if your identifiable information is needed, you will be informed.
- To meet legislative or regulatory requirements, such as reporting notifiable diseases.
- To send reminder letters about your health care and management. You can choose not to have your health information used in some or all of the ways mentioned above, but this might affect how effectively we can manage your healthcare.

1) I have read the information above and understand the reasons why my information must be collected. ☐
2) I understand that I am not obliged to provide any information requested of me, but failure to do so may compromise the quality of health care and treatment given to me. ☐
3) I am aware of my rights to access the information collected about me, except in some circumstances where access may be legitimately withheld. I will be given an explanation in these circumstances. ☐
4) I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained. ☐
5) I consent to the handling of my information by the practice for the purpose set out above, subject to any limitations on access or disclosure of which I notify this practice. ☐
6) I understand that the Alpine Health Centre is not an emergency service provider. ☐
7) I understand that Alpine Health Centre is a health service and does not provide primary care management. I am responsible for ensuring the management of my care via my health provider or other care provider. ☐

Terms and conditions of service: ☐
All accounts must be paid daily or via Medicare, DVA, NDIS, NDIA or Health Insurance Fund. The patient shall pay any expenses, costs, or disbursements incurred by Alpine Health Centre® in recovering any outstanding monies, including our Debt Collection Agency Fees and Solicitor's Fees.

OR

I am **unsure** and **would like to discuss this further with someone** from the medical practice before I sign. ☐
Please raise your concerns with the treating clinician.

Name: ..... **DOB:** .....

Signature: ..... **Date:** .....

Signed as Guardian: ..... **Date:** .....

(Power to make decisions on behalf of a child or another person about personal matters).

Name: ..... **Relationship:** .....