New Patient Registration Form

Please complete all questions

COASTAL IMMUNOLOGY
and allergy clinic
Email: reception@coastalimmunology.com.au

PATIENT INFORMATION

Title First Name Last Name

Address

Suburb State Postcode

Date of Birth / / Sex: Male Female Other

Day Time Phone After Hours Phone

Email address Occupation

Emergency Contact Relationship Contact number

Do you require an interpreter? Yes No

IF THE PATIENT IS A MINOR

Please complete if patient is 17 years or younger

Mother Full Name Mother Contact

Mother Address

Father Full Name Father Contact

Father Address

Who does the child live with most of the time?

Are there Court Orders in place? Yes No

If YES, has the other Parent/Guardian given consent for patient consultation? Yes No Not required

Guardian Carer (if different to above) Guardian/Carer Contact

MEDICARE/HEALTH INSURANCE INFORMATION

Medicare No Ref No (number next to name) Expiry date /

Dept. Veteran Affairs Card No: Expiry date /

Health Care/Concession Card No. Expiry date /

Private Health Fund Membership No Reference No

Is this visit related to Workers Compensation or Third Party Injury? Yes No

If YES, please provide your approval letter. If you have not organised pre-approval from your Insurance Company you will be charged the Workers Compensation rate for your visit. You will then need to claim the fee back from your insurance company.

MEDICAL REFERRER INFORMATION

Referring Doctor Name

Are there any other medical practitioners (including your regular GP) you would like to have copied on your correspondence apart from your referring doctor? Please list below

Name Address Phone

Name Address Phone

HOW DID YOU FIND OUT ABOUT THIS CLINIC? (please select most applicable)

☐ Relative ☐ Friend ☐ GP ☐ Specialist ☐ Website ☐ Internet Search

☐ Advertising ☐ Other

PRIVACY CONSENT AND INFORMATION

Coastal Immunology takes our patient's privacy seriously. We comply with The Privacy Act 1988 – for further information please visit ***https://www.oaic.gov.au/privacy-law/privacy-act/***

Coastal Immunology requires your consent to collect, use, and disclose information about you for the primary purpose of providing quality health care. Coastal Immunology stores your information digitally on a secure firewall-protected server. We require you to provide us with your personal details and a full medical history to allow us to properly assess, diagnose, treat and advise you on all your health care needs. Not providing consent may restrict the quality and scope of the healthcare we are able to provide you.

Please read the following carefully before signing. We encourage you to ask questions or seek clarification if needed.

By ticking the box below and printing your name (as a patient or guardian of a patient), you acknowledge the following:

☐ I give consent for my personal health information to be used for administrative purposes to assist in the running of Coastal Immunology and the coordination of my care, including disclosure to others involved in my healthcare such as referring doctors, treating doctors/specialists, allied health services and diagnostic service providers within and outside of Coastal Immunology.

☐ I give consent to be part of Coastal Immunology's appointment reminders and notifications.

☐ I authorise Coastal Immunology to leave messages on my voicemail/answering machine.

☐ I have read and understand the above information. I understand I am free to withdraw my consent at any time by contacting Coastal Immunology.

Thank you for completing this form. Please sign or initial below.

Signature Date

Name of Parent/Guardian/Carer (if patient under 18 years of age)

Once completed, please save this form with your full name as the file name, and email to ***reception@coastalimmunology.com*** or fax to ***02-4321 0669***

Patient Health History Form

Please complete all questions to the best of your knowledge

COASTAL IMMUNOLOGY
and allergy clinic

Email: reception@coastalimmunology.com.au

Patient Name: First Name | Surname | Date:

RELEVANT FAMILY MEDICAL HISTORY

(Immediate family only – father/mother/sibling/offspring)

Family Member	Date diagnosed	Condition/Disease

PREVIOUS HOSPITALISATIONS

List allergy/respiratory/autoimmune-related hospitalisations only, if any

Approx Date	Reason for Attendance	Diagnosis/Treatment given

CURRENT MEDICATIONS

Please list all current medications/drugs you are currently taking, including over the counter medications, vitamins, herbal remedies, aspirin etc

Medication Name	Dosage	Frequency

REACTIONS/ALLERGIES

Please list any/all past reactions, intolerances or allergies if known

Approx. Date/Year	Substance (if known) e.g. food	Reaction

DIET

Restrictions (if any)	Inclusions (if any)

Do you smoke? Yes ☐ No ☐ Substance ☐ Amount per day ☐

Do you consume alcohol? Yes ☐ No ☐ Amount per day/week ☐

AUTOIMMUNE PATIENTS ONLY

Previously diagnosed autoimmune conditions

Date	Disorder	Treatment

Previous relevant surgical procedures

Date	Procedure

Previous medical specialists seen

Date	Name	Reason	Outcome

Previous medications

Date	Medication	Reason administered	Outcome

Previous tests (please bring with you or have sent to us prior)

Date	Test	Reason/Result

Ongoing Chronic Symptoms

Date commenced	Symptom	Severity (interference with daily functioning 1-10). Where 1 is functioning ok, 10 is not functioning at all)

What are your current top 3 concerns:

1.

2.

3.

What, if anything, do you believe may have triggered your disorder/symptoms?

What outcome do you hope for from your consultation today?

Thank you for taking the time to complete this form. The information you provide assists us in providing you with quality healthcare.