NEW PATIENT DETAILS

Date: ___/___/___

Name of Patient:
Title: _____ First name: _____ Surname: _____

Preferred name: _____

Date of birth: _____

Medicare Number: _____ Ref: _____ Expiry: _____

Concessions: ☐ None Entitlement No: _____
☐ Health care Card
☐ Pensioner Expiry date: ____/____/____
☐ Veteran – All/Specified

Private Hospital Insurance: ☐ Yes ☐ No **Fund Name:**_____

Home Address: _____

_____

Postal Address: _____

Telephone: Home: _____Work: _____Mobile: _____
(We will use your mobile number to contact you for appointment reminders and recalls. Please let us know if you do not want this to happen.)

Country of birth: _____ **Occupation:** _____

Guardian/next of kin/Emergency Contact: (if not the same let us know)

Name: _____ Relationship: _____

Telephone: Home: _____Work: _____Mobile: _____

Would you like to receive the Practice electronic newsletter? ☐ Yes ☐ **No**

Your email address: _____

Cultural background: Are you? ☐ **Aboriginal** ☐ **Torres Strait Islander**
☐ **Neither Aboriginal nor Torres Strait Islander**

The information you give us about yourself is essential for administration, investigations and the management of your health. This information will be kept confidential and will not be released to any individual or organisation without your written consent, except when we are obliged by law to notify the Department of Health and Ageing for disease notification as per the Privacy Policy displayed.

I have read and agree to this: _____

NEW PATIENT MEDICAL INFORMATION

First name: _____ Surname: _____

Preferred name: _____

Previous GP / Surgery_____

Religion _____

Medications (including natural / alternative therapies)

_____
_____
_____
_____

Allergies to medications: _____
Other Allergies: _____
_____

Any significant illnesses/ operations / hospitalisations in the past.

_____
_____
_____
_____
_____

Are you a smoker or have you been in last 2 years? Yes / No
If so, how many per day? _____

Do you consume alcohol? Yes / No
If so approximately how many standard drinks per Day / Week? _____

Any significant family history: (eg heart disease, diabetes, cancers) _____
_____
_____
_____
_____
_____

Overseas Travel in past 2 years Yes / No
If yes – to where?_____

Have you had a GP Management Plan, Team Care Arrangement Plan or Mental Health Care Plan done for you by a Doctor in the past? Yes / No

Please give this form to your doctor.