New Patient Information

<table>
<tr><td>Please Circle:</td><td colspan="3">Miss / Ms / Mrs / Dr / Mr / Mst / ....</td></tr>
<tr><td>Surname:</td><td colspan="3"></td></tr>
<tr><td>First Name:</td><td colspan="3">______________________________
‘Known as’ (if different to first name):</td></tr>
<tr><td>Gender:</td><td colspan="3"></td></tr>
<tr><td>Date of Birth:
Country of Birth:
Identify with any Cultural Group?:
Aboriginal/Torres Strait Islander</td><td colspan="3">______________________________
____
☐ Yes ☐ No ______________________
☐ Yes ☐ No</td></tr>
<tr><td>Street Address:</td><td colspan="3">No & Street:______________________________
Suburb: ______________________State: ___________</td></tr>
<tr><td>Postal Address:
(If different to street address)</td><td colspan="3"></td></tr>
<tr><td>Home Phone:</td><td colspan="3"></td></tr>
<tr><td>Work Phone:</td><td colspan="3"></td></tr>
<tr><td>Mobile Phone :</td><td colspan="3"></td></tr>
<tr><td>Email Address :</td><td colspan="3"></td></tr>
<tr><td>Medicare Number:</td><td>No: / Ref:</td><td>Expiry Date</td><td></td></tr>
<tr><td>DVA Number:
- Gold / White (Please circle)</td><td></td><td>Expiry Date</td><td></td></tr>
<tr><td>Pension Number:</td><td></td><td>Expiry Date</td><td></td></tr>
<tr><td>Health Care Card Number:</td><td></td><td>Expiry Date</td><td></td></tr>
<tr><td>Occupation/Employment:</td><td colspan="3"></td></tr>
<tr><td>Marital Status: (Please circle)</td><td colspan="3">Single / Married / De-Facto / Separated / Divorced / Widowed</td></tr>
<tr><td>*Next of Kin:</td><td colspan="3">Name: ______________________
Phone No: ______________________
Mobile No: ______________________
Relation to you: ______________________</td></tr>
<tr><td>*<u>Emergency</u> Contact:
(A person we can contact if necessary – eg neighbour, friend - other than Next of Kin)</td><td colspan="3">Name: ______________________
Phone No: ______________________
Mobile No: ______________________
Relation to you: ______________________</td></tr>
</table>

25/02/2021

 PATIENT NAME: ______________________________

Consent for Reminders:
Our practice uses a system for appointment and health reminders (eg immunisation, annual health checks, cervical screening and other health reviews). The practice sends these reminders by either post, email, telephone or SMS
I consent to being contacted with reminders:

☐ Yes ☐ No

Our practice also sends information to the Australian Immunistion Register and Cervical Screening Register. These registers also send reminders, which can be helpful if you move.
I consent to being contacted with reminders from other registers:

☐ Yes ☐ No

What is your preferred method of contact (select 2):

☐ BP App OR ☐ Mobile Phone/SMS
☐ Mail OR ☐ Email

Your Health History
***Do you have or had a history of?**

☐ Asthma ☐ No ☐ Yes Date/Year of onset
____

☐ Diabetes ☐ No ☐ Yes Date/Year of onset
____

☐ Hypertension ☐ No ☐ Yes Date/Year of onset
____

☐ Chronic illness ☐ No ☐ Yes Date/Year of onset
____

☐ Smoker ☐ No ☐ Yes Date/Year of onset/Quit
____

☐ Other ______________________________
☐ Weight (Approx.) __________ ☐ Height (Approx.) __________
☐ Chronic illness ☐ No ☐ Yes Date/Year of onset
____

☐ Influenza ☐ No ☐ Yes Date/Year of onset
____

☐ Cervical Screening ☐ No ☐ Yes Date/Year of onset
____

☐ Alcohol Consumption (Drinks Per Week): ______________________________

***Allergies - Do you have any allergies?**
☐ Yes (Please list below with nature of reaction eg. Anaphylaxis, Swelling, Redness or Other) ☐ No known allergies

____

____

☐ Sensitive to any drugs or dressings? (Please list below) ☐ None known

____

____

Current Medications **(including over the counter medications, vitamins and minerals)**

____

____

New Patient Information

***Family History - Has any members of your family had?** (List relationship to you)

☐ Diabetes ☐ No ☐ Yes Relationship ____________________

☐ Asthma ☐ No ☐ Yes Relationship ____________________

☐ Heart Disease ☐ No ☐ Yes Relationship ____________________

☐ Mental illness ☐ No ☐ Yes Relationship ____________________

☐ Cancer ☐ No ☐ Yes Relationship ____________________

I confirm that the information I have given is correct. I consent to sharing of all relevant information between the GPs, Specialists, Nurses, Allied Health providers and non-clinical staff for the purpose of managing my health. I understand this information will be used to fulfil their duties in the course of planning and management of my health.

Patient's Signature ____ **Date** ______________________________

*please note all question marked with (*) must be answered