GAREMA PLACE

New Patient Information Form

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master ☐ Other

First Name: **Middle Name:**

Surname: **Known As:**

Date of Birth: / / **Age:** **Gender:**

Medicare No: __ __ __ __ __ __ __ __ __ __ **Ref No:** **Expiry Date:**

If patient is under the age of 16 years old please complete this section for payment:

Parent/Adult Full Name: _____

Address: _____

Telephone Number: _____

Existing patient of this practice? ☐ Yes ☐ No

Date of Birth: / /

Medicare number (if they have not attended GPS): __ __ __ __ __ __ __ __ __ __

To assist with health initiatives - are you Aboriginal or Torres Strait Islander?

☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal & Torres Strait Islander ☐ No

Ethnicity: _____ **Country of Birth:** _____

Street Address:

Suburb: **Postcode:**

(only provide the phone numbers that you are happy for a message to be left)

HOME Phone: **WORK Phone:**

MOBILE Phone: **EMAIL:**

Would you like to be contacted via SMS (mobile text message) for: appointment reminders, recall and other test reminders or medical services we offer?

☐ Yes ☐ No

GAREMA PLACE SURGERY

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Concession Card: (Please circle)	DVA Gold / White Health **(If white card please state condition)**	Pension	Health Care Card	Private
Card Number:		**Expiry Date:**		
Occupation:				

Next of Kin:
Full Name: _____

Telephone Number: _____Relationship to you: _____

Existing patient of this practice? ☐ Yes ☐ No	Date of Birth: / /	Medicare number (if they have not been here before): __ __ __ __ __ __ __ __ __ __

Do you give permission for Garema Place Surgery to contact your next of kin if urgent?
☐ Yes ☐ No

Emergency Contact: (or same as above ☐)

Full Name: _____

Telephone Number: _____ Relationship to you: _____

PLEASE NOTE OUR CANCELLATION POLICY: A cancellation fee will be charged if you do not attend a scheduled appointment without notice or cancel within 2 hours of a scheduled appointment.
Please acknowledge you understand our cancellation policy. YES ☐

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Do you have, or have you had, a history of?

Operations: _____

Asthma: _____

Diabetes: _____

Hypertension: _____

Illness: _____

Do you have any allergies or are you sensitive to drugs or dressings? Yes ☐ No ☐

If yes, please list the reaction: _____

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

_____

_____

Pap Smear: Date of last Pap Smear / / Don't know ☐ Haven't had one ☐

Family history – have any members of your family had:

Diabetes ☐ Asthma ☐ Heart Disease ☐ Mental Illness ☐ Cancer ☐ Other ☐

_____

_____

Social history:

Smoking Yes ☐ No ☐ _____ cigarettes per day, or ceased smoking date / / .

Alcohol Yes ☐ No ☐ _____ glasses per day / week / month (please circle)

_____

_____

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Immunisations – have you had the following immunisations?

Tetanus booster	☐	Date: / /		Don't know	☐	Haven't had one	☐
Influenza (Flu Vacc)	☐	Date: / /		Don't know	☐	Haven't had one	☐
Pneumococcal	☐	Date: / /		Don't know	☐	Haven't had one	☐

Children's immunisations – if completing this form for a child, are their immunisations up to date?

Yes ☐ No ☐ Don't know ☐

Your Privacy and Rights as a Patient

Garema Place Surgery is fully compliant with all Commonwealth and Territory Privacy Legislation requirements. In line with the Amended National Privacy Principles 2014 – your medical record is a confidential document. It is the policy of this practice to maintain security of personal health information at all times and to ensure that this information is only available to authorised members of staff.

To obtain a copy of our privacy policy, please ask at reception or alternatively it is available on our website.

If you have a problem with any aspect of our service, we would like to hear about it. Please contact our Practice Manager in the first instance. We take your concerns very seriously.

☐ I have read the practice information sheet and the practice privacy policy and understand all the fees and conditions.

_____ _____/_____/20_____

Signature Date