

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

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Please present card to Reception staff

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

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: / /

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**

PHOTO ID TO BE SHOWN TO RECEPTION STAFF IF OVER 16 YEARS OLD

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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	<input type="checkbox"/>	Date: / /	<input type="checkbox"/>	Don't know	<input type="checkbox"/>	Haven't had one	<input type="checkbox"/>
Influenza (Flu Vacc)	<input type="checkbox"/>	Date: / /	<input type="checkbox"/>	Don't know	<input type="checkbox"/>	Haven't had one	<input type="checkbox"/>
Pneumococcal	<input type="checkbox"/>	Date: / /	<input type="checkbox"/>	Don't know	<input type="checkbox"/>	Haven't had one	<input type="checkbox"/>

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.

Our premises are monitored with CCTV cameras for the safety and security of staff and patients.

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

**Office use only
(Reception)**

**Office use only
(Nurse)**