GAREMA PLACE SURGERY

# New Patient Information Form

Welcome to Garema Place Surgery. Please visit www.garemaplacesugery.com.au for information about our practice.

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

**First Name:** **Middle Name:**

**Surname:** **Known As:**

**Date of Birth:** / / **Age:** **Gender: M ☐ F ☐ Other ☐**

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

**If patient is under the age of 17 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:**
(Personal email preferred)

**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 DVA 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** ☐

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

**If yes, please list the reaction:** _____

**Do you have any allergies or adverse reactions to medication, products foods etc?** _____

**Do you smoke? (Circle) Yes or No _____ cigarettes per day, or ceased smoking date / / .**

**How often do you have a drink containing alcohol? _____ glass per day / week / month (please circle)**

**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/Nurse)**

**/**