New Patient Information Form

ALL INFORMATION COLLECTED IS CONFIDENTIAL

Please ask for a copy of our 'Privacy Policy' if you have any concerns.

Title	☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Mast ☐ Dr ☐ Other			
First Name		Surname		
Preferred Name		Date of Birth		
Gender				
Street Address				
Suburb & Post Code				
Home Phone		Work Phone		
Mobile Phone				
Email				
Ethnicity				
Language(s) Spoken	Interpreter required ☐			
Occupation				
Medicare Number	IRN		Expiry	
DVA Number Gold/White			Expiry	
Pension Number			Expiry	
Health Care Card No.			Expiry	
Private/Overseas Student Health Insurance			Expiry	
Next of kin contact, Full Name & Phone number, Relationship				
Emergency contact, Full Name & Phone number, Relationship				

Are you (is the person) of Aboriginal or Torres Strait Islander origin?

☐ No ☐ Yes Aboriginal ☐ Yes Torres Strait Islander

☐ Yes, both Aboriginal and Torres Strait Islander

We are asking this information to determine if you may be eligible for Medicare services and prescription benefits, and to help improve health outcomes under the 'Closing the Gap' initiative. Your information will remain confidential. Please ask us if you have any questions.

Reminder Systems:

Our Practice uses a reminder system. We will contact you by post, email, telephone or SMS if results or correspondence about you needs further discussion and to remind you of scheduled vaccinations and overdue tests. We use HealthEngine to send appointment reminders and recall messages.

Our practice sends information to the Australian Immunisation Register and Cervical Screening Register. These registers also send reminders. We can access 'My Health Record' but only with your consent.

A copy of our privacy policy is available on our website.

I consent to being contacted.

☐ Yes ☐ No

Please let us know if you have any questions about this policy.

Signature of patient or guardian **Date**

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YOUR HEALTH HISTORY

☐ Arthritis	☐ High Cholesterol	☐ Heart disease
☐ Asthma	☐ Diabetes	☐ Stroke
☐ High Blood pressure	☐ Mental Illness	☐ COPD
☐ Operations		
☐ Other		

MEDICATIONS

1.	**6.**
2.	**7.**
3.	**8.**
4.	**9.**
5.	**10.**

Do you have any allergies against medications or dressings? ☐ Yes ☐ No

Medication	Type of reaction	Year

IMMUNISATIONS

Are all childhood vaccinations up to date? ☐ Yes ☐ No

In recent years any of the following immunisations?

☐ Tetanus	Date:	☐ Pneumococcal (pneumonia)	Date:
☐ Hepatitis B	Date:	☐ Gardasil (cervical cancer)	Date:
☐ Influenza	Date:	☐ Other	Date:

FAMILY HISTORY (i.e. Diabetes, Heart disease, Stroke, Asthma, Cancer, Mental Illness etc.)

Father		Grandparents	
Mother		Genetic diseases	
Brothers/sisters		Other conditions	

OTHER HISTORY

☐ Smoking	Never/Current/Previous	How many years?	How many per day?
☐ Alcohol	If YES, current or past?	How often?	On average how many?
☐ Recreational drugs			
☐ Pap Smear	Date:	☐ Breast Check	Date:

Height: _____ cm **Weight:** _____ kg