New Patient Information Form

Surname:		**Title:**					
First Name:		**Date of Birth:**					
Street Address:							
Suburb:		**State:**		**Postcode:**			
Home Phone:							
Mobile Phone:							
Email:							
Medicare Number :	☐☐☐☐☐☐☐☐☐☐ / **Ref:** ☐			**Expiry Date:**			
DVA Number:	only if applicable	**Expiry Date:**		only if applicable			
Pension Number:	only if applicable	**Expiry Date:**		only if applicable			
Health Care Card Number:	only if applicable	**Expiry Date:**		only if applicable			
Next of Kin (Name and Phone Number):	Relationship:						
Emergency Contact (Name and Phone Number at different address):	Relationship:						

Please circle as appropriate: **Aboriginal**  **TSI**  **Neither**

Are you?
(Aboriginals and Tories Strait Islanders can qualify for special schemes, please enquire are reception)

What is your ethnicity? (Australian/ Indian / Chinese / Greek, etc)_____

Allergies:
List any known allergies_____

Social History:
Tobacco: (please select one)
- ☐ Smoker _____ per day / week (circle one)
- ☐ Ex-Smoker Date Ceased:_____
- ☐ Never

Alcohol: _____ day / week / month (circle the one applicable)
Drug Use: _____(type and frequency)

Height: _____cms **Weight:** _____kgs

Family History- Has any members of your family had?
- ☐ Diabetes
- ☐ Asthma
- ☐ Cancer
- ☐ Heart Disease
- ☐ Mental Illness

Please Turn Over

Immunisations- Have you had the following immunisations?

Tetanus Booster	Date_____	☐ Don't Know	☐ Haven't had one
Hepatitis B	Date_____	☐ Don't Know	☐ Haven't had one
Hepatitis A	Date_____	☐ Don't Know	☐ Haven't had one
Influenza	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 is their immunisations up to date?

☐ Yes ☐ No

For those 65 years and older: When was the last time you were immunised?

Influenza:	Date_____	☐ Not sure	☐ Never
Pneumococcal pneumonia:	Date_____	☐ Not sure	☐ Never

Sun Protection: How often do you use the following to protect yourself from the sun when outdoors?

	Always	Often	Sometimes	Rarely	Never
Protective clothing:	☐	☐	☐	☐	☐
Sunscreen Creams:	☐	☐	☐	☐	☐

Females: When did you last have?

Pap Smear	Date_____	☐ Not sure	☐ Never
Breast Check	Date_____	☐ Not sure	☐ Never
Overall Check	Date_____	☐ Not sure	☐ Never

Males: When did you last have?

An overall check up	Date_____	☐ Not sure	☐ Never

Do you give your consent to be on our reminder system?

For various conditions such as Immunisations, Diabetic care, Pap smears, Heart Care, etc ☐ Yes ☐ No ☐ Not Sure

How did you find out about us? _____

(Google, Sign, Chemist, Friend, etc)

If you hold a Pension Concession Card you will be Bulk Billed. If you are a Gold Coast Resident with a Health Care Card or Student Card or the patient is under the age of 16 then you will be Bulk Billed.

Otherwise, please check with reception how much the consultation will cost. Please note we can process your Medicare claim and refund, please ask at reception.

Method of Payment (circle): Cash Credit Card EFTPOS

Patient Signature: _____ **Date:** _____

THE INFORMATION YOU HAVE PROVIDED IS STRICTLY CONFIDENTIAL