



Title: Mr. Mrs. Ms. Miss. Mast.

Gender: M F Other

First Name: _____

Family Name: _____

Date of Birth: ____/____/____

Occupation: _____

Medicare Number: _____

Reference Number: _____

Expiry Date: ____/____/____

Marital Status: _____

Mobile: _____ Home Phone: _____ Work Phone: _____

Address: _____

Suburb: _____

Postcode: _____

Postal Address (if different to above): _____

Suburb: _____

Postcode: _____

Email Address: _____

Please Circle: Are you an Aboriginal, Torres Strait Islander or both? Yes No

Cultural Background/ Ethnicity: _____

Please Circle: Pension / Health Care Card Number:

_____ Expiry: _____

DVA Card Veteran Affairs Please circle: Gold / White

_____ Expiry: _____

Next of Kin Name: _____ Relationship: _____

Contact Number: _____

Emergency Contact Name: _____ Relationship: _____

Contact Number: _____

How did you find out about us? _____

Do you consent to SMS or other relevant medical reminders? Yes No

*** Please turn over ***

CONSENT: In keeping with the Privacy Act, we require your consent with regard to the following.

1. I give consent for Medical information to be obtained by my doctor for the purpose of my medical treatment and passed on to third parties eg specialists for the purpose of further treatment.
2. I give consent for medical reminders, recalls and updates to be sent either my mobile via SMS, email or postal address.
3. I give consent for my contact details to be retained for the purpose of contacting me regarding medical matters or appointments.
4. I give consent for SMS reminders to be sent to me on my mobile prior to my appointment the next day.
5. I give consent for my personal information to be uploaded to MyHealthRecord via a Shared Health Summary or Event Summary to aid in the consistency and continuation of medical treatment.
6. Our clinic participates in population health planning with the Australian Government via our Primary Health Network and Medicare. To do this we submit **de-identified** health data, which means it does not include any of your identifying information such as name, DOB, address, Medicare number etc. It is also encrypted before being sent. This data is for research purposes only and will never be sold or made available to third parties. It will only ever be used to assist in research for policy development, program management, disease burden analysis and current health trends. By ticking this box, you are consenting to the use of your de-identified data.

Signature: _____

Date: _____

By signing this new patient form you are providing consent to the above.



First Name: _____

Family Name: _____

Date of Birth: ____/____/____

Current Medical History

Do you have any Allergies? Please tick - Yes No Unknown

If 'Yes' Please list down known allergies you may have.

Are you currently taking any medications?

Please tick - Yes No

If 'Yes' Please list down current medication.

Are you currently using any complementary or alternative medicines or therapies?

Please tick - Yes No

If 'Yes' Please list down current medications or therapies.

Past Medical History

Do you smoke? Yes No

If 'no' have you ever smoked? Yes No

If 'yes' how long ago did you quit? _____

How many per day? _____

Do You Drink Alcohol? Yes No

Frequency _____

Have you tried Quitting Yes No

Have you ever had or have any of the conditions below? If 'Yes' Please Circle.

Diabetes Kidney Disease Asthma Bowel Cancer Breast Cancer

High Blood Pressure Heart Problems Epilepsy Depression/Anxiety

Other mental health

Other: _____

Is there a Family History of any of these conditions? If 'Yes' Please Circle.

Diabetes Kidney Disease Asthma Bowel Cancer Breast Cancer

High Blood Pressure Heart Problems Epilepsy Other: _____

If 'Yes' state relationship to you _____