New Patient Form

Date of Initial Consultation: ..... / ..... / .....

Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master ☐ Dr

Last Name: ..... Given Name(s): .....

Date of Birth: ..... Gender: .....

Medicare Number: ☐☐☐☐ ☐☐☐☐☐ ☐ Ref No: ☐ Valid to: ☐☐ ☐☐☐☐

Do you have a Health Care / Pension / DVA Card? ☐ Yes ☐ No

Are you of Aboriginal or Torres Strait Islander origin?

☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Both, Aboriginal and Torres Strait Islander

What is your cultural background/Country of birth? .....

Is English your first language? ☐ Yes ☐ No If not, do you require an interpreter? ☐ Yes ☐ No

Street Address: .....

Suburb: ..... Postcode: .....

Home Phone No: ..... Work Phone No: .....

Mobile No: ..... Email: ..... @ .....

What is the best way for us to contact you? ☐ Home Phone ☐ Work Phone ☐ Mobile

Can we SMS appointment reminders to you? ☐ Yes ☐ No

Can we leave a message on your message-bank regarding an appointment? ☐ Yes ☐ No

Can we leave a message with a family member who answers the phone regarding an appointment? ☐ Yes ☐ No

If *yes* - please state their name and relationship to you: .....

Can we put your name on a formal reminder system for preventive care? ☐ Yes ☐ No

PLEASE SIGN HERE TO CONSENT TO THE ABOVE: .....

Emergency Contact: ..... Relationship: ..... Ph No: .....

Next-of-Kin: ..... Relationship: ..... Ph No: .....

Please list any allergies: .....

Smoking: ☐ Non-smoker ☐ Smoker - how many/day: ..... ☐ Ex-smoker - year stopped: .....

Alcohol: ☐ Non-drinker ☐ Drinker - how many days/week: ..... How many std drinks/day: .....

What recreational activities do you participate in? .....

..... Elite athlete? ☐ Yes ☐ No

Marital Status: ..... Occupation: .....

Accommodation: ☐ Own home ☐ Nursing home ☐ Other: .....

Live with: ☐ Alone ☐ Spouse ☐ Other: .....

Privacy Statement:

We value your privacy. All information about you is kept in the strictest confidence and we operate in accordance with the *Privacy Act (1988)* and *Privacy Amendment (Enhancing Privacy Protection) Act 2012*. We are committed to protecting your privacy and ask for your consent for the use and disclosure of your personal health information as required during your health care.

☐ **I CONSENT TO THE USE AND DISCLOSURE OF MY PERSONAL HEALTH INFORMATION AS REQUIRED FOR MY HEALTH CARE**

Signature**:** ..... Date: .....