NEW PATIENT FORM

This information is private and confidential and is for use in your clinical file only

Personal Details:					
Title	Mr Mrs Ms		Miss Dr	Other:	
Surname			Date of Birth		
First Name			Middle Name		
Street Address			Preferred Name		
Suburb			**Post Code**		
Home Phone:		**Mobile Phone:**		**Work Phone:**	
Email Address:					
Occupation:			Past Occupation		

Health Care Details:			
Medicare Number		**Ref Number:**	**Expiry:**
Pension Number		Expiry Date:	
Concession Healthcare Card		Expiry Date:	
DVA Gold / White (Please Circle)		Expiry Date:	

Emergency Contact Details:		
Next of Kin (Name):	Contact Number:	Relationship:
Emergency Contact (Name):	Contact Number:	Relationship:

Australia is a genuinely multicultural society. To tailor appropriate care, encourage understanding and appreciation between people from different nationalities and backgrounds please complete this section:

Do you require a Translator? Yes No	**Country of Birth/Ethnicity:**
To assist with health initiatives – are you Aboriginal or Torres Strait Islander? (please circle) Aboriginal Torres Strait Islander Aboriginal & Torres Strait Islander No	

DID NOT ATTEND APPOINTMENTS – Failing to turn up for your appointment, will result in Bulk Billing NO LONGER being available to you. By missing appointments this denies other patients who need to be consulted. Please see Reception for our Did Not Attend Policy.

How did you choose this surgery? Please circle - *Website* *Google* *Facebook* *Friend/Family* *Other*

Signature______________________________ Date______/_______/_______

PLEASE *TURN OVER*

Surname: ___________________________ First Name: ____________________ Date of Birth ___/____/_____

Current medications **(including over the counter medication, vitamins, minerals and/or health supplements):**

____

____

____

Do you have any **allergies or are you sensitive** to drugs or dressings**?**

☐ Yes (Please specify below) ☐ No

____

____

Your Health History: Do you have or have a history of? (please tick)			
	Operations (give details):		Hypertension
	Asthma		Chronic Illness (give details):
	Diabetes		Other (give details):

If this information is for your child please provide a copy of your child's immunisation history to the receptionist.

Family History: Have any members of your family had? (please tick and details eg: mum,dad,sister,grandparent)			
	Diabetes		Mental Illness (give details)
	Asthma		Cancer (give details)
	Heart Disease		Other (give details)

NOTE: This section may **not** be applicable for some patients**.**

Social History:	
Do you smoke? Yes: ______/day No	Past smoking history: Nil Light Moderate Heavy Which year did you stop smoking? _____________
Do you drink alcohol? Yes: ______/day No	Past drinking history: Nil Light Moderate Heavy Which year did you stop drinking? _____________
Females: When did you last have? Pap Smear Date: ___________ Not Sure/Never Breast Check Date: ___________ Not Sure/Never	**For those 65 years and older: When was the last time you were immunised?** Influenza Date: __________ Not Sure/Never Pneumococcal Date: __________ Not Sure/Never

At Brewer Street Medical Centre we strive to provide high quality care, appropriate to meet our client's health care requirements.

By becoming a patient of Brewer Street Medical Centre and signing this new patient form, I agree and consent to the following:

I consent to the use of my personal health information by Brewer Street Medical Centre and other health care providers involved in my medical treatment and health care within this centre.

I consent Brewer Street Medical to submit on my behalf all accounts to Medicare Australia for consultations attracting a Medicare Benefit payable to General Practitioners. I agree to pay a Private Fee for any services that are not covered by Medicare. The GP will advise me before any treatment attracting a fee is performed.

I consent to the disclosure of my personal health information by the above named practice to other health care providers involved directly or indirectly involved in my personal health care or medical treatment. inc Australian Immunisation Register and Pap Smear Register.

As part of preventative health services offered by this practice, we send out follow up reminders and recalls. I consent to receive follow up reminders and recalls to be sent to the above address and/or mobile number. Our preferred method is via SMS. If you do not consent please advise us immediately. No spam or unnecessary SMS are ever sent.

Signature____ Date_______/________/________

Printed Name ________________________________ (If the patient is **under 16 years** the parent/guardian is to sign)