NEW PATIENT INFORMATION FORM

We are committed to providing our patients with the best care, to do this it is essential that your medical records are up to date and accurate.

Title _____ Surname _____Given Names_____

Preferred Name_____

Date of Birth _____ Gender_____ Pronouns_____

Marital Status _____

Home Address_____

_____

Mailing Address _____

Occupation_____

Home Phone _____ Work Phone _____

Mobile Phone _____ Consent for SMS Yes/No _____

Email Address_____

Medicare Card Number _____

Medicare Card Ref Number _____ Medicare Card Expiry Date_____

Pension, Health Care Card or DVA Number _____

Type of Veterans Affairs Card_____ Expiry Date _____

Private Health Cover Name_____ Number_____

(Cover Included Hospital, Extra, Ambulance)_____

Next Of Kin_____

(Name, Phone No, Relationship)

Emergency Contact _____

(Name, Phone No, Relationship)

Ethnicity – eg Australian non indigenous, First Nations/Indigenous, Other (please specify)

_____

Do you require an Interpreter? If Yes which language?_____

88 – 90 Partridge Street
Glenelg South
Ph: (08) 8490 7810 Fax: (08) 8490 6773 Email:reception@thrivefamilypractice.com.au

Health History – Do you have/had (Asthma, Diabetes, Hypertension, Chronic Illness)

_____

Do you have any allergies? If Yes please specify_____

_____

Are you a Smoker Yes/No_____ How many_____ Per Day / Week / Month

Alcohol Use Yes/No_____ How many_____ Per Day / Week / Month

Cervical Screening _____

CONSENT

Upon consent Thrive Family Practice may access my medical file and personal details for doctors and practice staff to converse with other doctors, specialists and their staff other allied health care providers and pharmacists who are directly involved in my care for home medication reviews or case conferences.

Our practice uses a reminder system to help you maintain your health. The practice sends reminders by SMS, telephone or post for procedures, vaccinations, cervical screening and other health reviews.

I understand that the practice participates in National and State recall programs such as but not limited to Breast Screen SA, Cervical Screening, Immunisation Programs, National Bowel Screening.

I consent to being contacted with reminders to help me maintain my health.

I understand that the practice participates in the My Health Record scheme and my doctor may view, upload and/or download health information from this system as required.

Name_____

Signature_____

Date_____

How did you hear about us?

Family/Friend_____

Thrive Family Practice Website_____

HotDocs_____

Google_____

Other_____

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