New Patient Registration Form

Upon booking a New Patient appointment, you will receive a link to fill out an online New Patient Registration form. It can also be completed on our tablet in the clinic prior to your New Patient appointment (please allow extra time if you want to do this). Please only use this form if you will find it difficult to fill out an online form.

Contact Details

Surname		Given Name	
Other Names		Date of Birth	
Sex at Birth (M/F)		Current Gender Identity (M/F/Other)	
Nationality/Ethnicity		Country of Birth	
Home Phone			
Home Address			
Home Phone		Mobile Phone	
Work Phone		Email	
Mobile SMS reminders consent	Yes/No	Todays Date	

Next of Kin (Emergency Contact)

Name		Relationship	
Home Number		Mobile Number	

Health Care Details for Billing Purposes

Medicare Number		Reference Number		Expiry	
Concession Card/Health Care Card/Pension Card		Reference Number		Expiry	
DVA Card		Colour			

Demographics

Ethnicity		First Language	
Aboriginal or Torres Strait Islander	No Aboriginal Torres Strait Islander Both	Interpreter Required?	

If the NEW Patient is under 16yo, please provide details for (Parent/Guardian)

Surname		Given Name			
Other Names		Date of Birth			
Medicare Number		Reference		Expiry	

LITTLE gem MEDICAL

Medical History

Allergies

List All Allergies, type of reaction and severity	

Medications

List All Medications (including any over the counter/ complimentary medication)	

Past Surgery

List All Past Surgeries and Year/Location	

Your Medical History (please circle)

Asthma	Yes/No	Arthritis	Yes/No
Diabetes	Yes/No	Epilepsy	Yes/No
Hypertension (Blood Pressure)	Yes/No	HIV/Hepatitis	Yes/No
Mental Health	Yes/No	Tuberculosis	Yes/No
Heart Disease/Stroke	Yes/No	Reflux	Yes/No
Cancer	Yes/No	Obstructive Sleep Apnoea	Yes/No
Major Accidents/Injuries	Yes/No	Migraine	Yes/No
Skin Cancer	Yes/No		
Other: List ANY Other Conditions not mentioned above			

Lifestyle Information and Risk Factors

Smoking	Never Smoked Smoker – How Many Per Day _____ Year Started _____ Ceased Smoking Year Started _____ Year Stopped _____ How many per day (average) _____	Alcohol	How Many Day per Week _____? How may Standard Drinks per day _____?

Family History

Please state who has the condition. Leave BLANK if no family history

Asthma	
Arthritis	
Diabetes	
Hypertension (Blood Pressure)	
Mental Health	
Heart Disease/Stroke	
Cancer	
Major Accidents/Injuries	
Skin Cancer	
Other: List ANY Other Conditions	

Past or Current Specialists

List All Current Specialist and the issue you see them for	

Agreement with Little Gem Medical

Little Gem Medical is committed to:

- Providing professional medical care
- Maintaining patient privacy/confidentiality
- Providing patients with information to allow for proper consent
- Keeping thorough and up to date medical records
- Enable best possible care by liaising with other healthcare providers where needed

Terms of Service

To assist us take care of your health, please read our Privacy Policy and Billing Policy (on our website or available at reception) and provide your consent to the following:

1. Keeping of your medical records, including medical photography
2. Transmission of these records, as clinically required to other healthcare providers
3. Utilisation of de-identified health information to third parties (via the primary health network) for the purposes of quality improvement and clinical audit activities.
4. The terms of our Privacy Policy as amended from time to time
5. The terms of our Billing Policy as amended from time to time

Patient Signature	
Guardian Signature (If patient is under 16yo)	

Request for Medical Records

I request my records to be obtained by Little Gem Medical for ongoing medical care. This includes:

- GP summaries, immunisation details, results and specialist letters
- Specialist Letters and Results
- Imaging or Pathology Reports and Results
- Hospital (Private or Public) Discharge Summaries, Notes and Results

Patient Signature	
Guardian Signature (If patient is under 16yo)	