NEWTOWN MEDICAL CENTRE

NEW PATIENT INFORMATION FORM

We are committed to providing our patients with the best care. To do this, it is essential that your health record is kept up to date and accurate. Please assist us by completing the following pages:

** = This information is completely voluntary and may help individualise and enhance your care.*
Any information is strictly private and confidential

TITLE	Mr Mrs Ms Miss Mst Other				
SURNAME		**FIRST NAME**			
DATE OF BIRTH	/ /	***SEX**	☐ MALE	☐ FEMALE	
ADDRESS					
		POSTCODE			
MAILING ADDRESS					
		POSTCODE			
PHONE NUMBERS	Mobile:	Home:	Work:		
MEDICARE CARE		REFERENCE NO (next to name)	EXP		
DVA NUMBER		☐ GOLD ☐ WHITE	EXP		
PENSION or HEALTHCARE CARD	CRN:	EXP			
PRIVATE HEALTH INSURANCE	Name of Company				
NEXT OF KIN	Name:..... Phone:..... Relationship to you:.....	**EMERGENCY CONTACT**	Name:..... Phone:..... Relationship to you:.....		
EMAIL					
***In which country were you born? (Ethnicity)**					
***Do you identify as any of the following?**	☐ Aboriginal ☐ Both	☐ Torres Strait Islander ☐ None			
***Do you require a translator**	☐ No	☐ Yes	Language		
SMOKING HISTORY	☐ Non-smoker				
	☐ Ex-smoker	Year stopped	☐ Light	☐ Moderate	☐ Heavy
	☐ Current smoker	Per day	Year started		
CURRENT ALCOHOL INTAKE	☐ Non-drinker				
	☐ Drinker	Days per week	Standard drinks per day		
ALLERGIES *Are you sensitive to anything? Food, medications, dressings etc…	☐ No ☐ Yes, please list allergy and reaction				
ANY SIGNIFICANT PAST MEDICAL HISTORY?					
HOW DID YOU HEAR ABOUT US?	☐ Yellow Pages	☐ Word of Mouth	☐ Health Provider/Nurse on Call		
	☐ Drove Past	☐ Internet/Website	☐ Other		

********** PLEASE TURN OVER TO COMPLETE DECLARATION **********

NEWTOWN MEDICAL CENTRE

I ……. Date of Birth ……/……/…….

- ☐ Confirm that all the above details are true and correct. I acknowledge that I have read and understand the policies and procedures outlined on the Practice Information Sheet. I understand this is a private practice and full payment is expected on the day of consultation and that late fees may be billed if I do not pay on the day. I understand that reception staff can assist with any queries I might have with the policies and procedures outlined in the Practice Information Sheet.

- ☐ Consent to receive sms messages and email correspondence which can include accounts, appointment reminders, clinic reminder messages and other email communication such as newsletters and health updates. (Please note that you may revoke your permission at any time.)

- ☐ Consent to the sharing of my information that has been collected to other providers (such as pathology, physiotherapists, psychologists, other GP's in this practice, locum services, specialists, Medicare for billing purposes etc.) in order to provide appropriate care, support and services according to my needs.

Please note: Your consent to share information is valid indefinitely or until otherwise altered or revoked. We *also must comply* with any legislative or regulatory requirements, ie. Notifiable disease.

……. (Signature) Date ……/……/…….