New Patient Information Sheet

easthills Medical Centre

Patient Details:

Title:	*Dr*	*Mr*	*Mrs*	*Ms*	*Miss*
Surname:			***Given Name:***		
Preferred name:			***DOB _____ / _____ / _____***		
Gender:			***Occupation:***		
Home Address:			***Phone Number:***		
Email Address:					
Interpreter needed? Yes □ No □			***Preferred Language:***		

Australian, not Indigenous □ **Aboriginal but not Torres Strait Islander** □

Torres Strait Islander but not Aboriginal □ **Aboriginal but not Torres Strait Islander** □

Others □ *(Ethnicity / Heritage)* _____

Emergency Contact ***Full Name:***	***Contact Number:***	***Relationship to Patient:***
Next to Kin ***Full Name:***	***Contact Number:***	***Relationship to Patient:***
Further Special Needs: *(if applicable)*		

Patient Billing History:

Medicare Number	***IRN No.***	***Expiry Date:***
Pension No:	***Expiry Date:***	
DVA No:	***Expiry Date:***	***Card Type:*** Gold □ White □

****PLEASE TURN OVER****

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Patient Medical History:

Allergies / sensitive to drugs or dressing? Yes / No (If applicable, please specify)	
Current Medication(s)	
Are your parents diagnosed with any medical condition? Yes / No (If Yes, please specify)	
Do you smoke cigarettes: Yes / No	**If yes, how many per day?**
Do you consume alcohol: Yes / No	**If yes, how many std drinks per week?**

Patient Consent:

Do you give consent for electronic communication? Yes □ No □	
Do you give consent for presence of third-party during consultation? (have requested the presence of my spouse, family member, guardian, friend, carer, interpreter or chaperone, during my consultation) Yes □ No □	
Do you give consent for presence of third party during consultation (presence of a third party being an interpreter, medical or allied health or nursing professional or student, general practice registrar or chaperone, during my consultation) Yes □ No □	
Complete medical history is important for you to obtain good health care. Please do not hesitate to discuss with the doctor if you are unsure of anything or cannot write it down. By signing below, you are consenting to the collection of your personal information, it may be disclosed by the practice for the following purpose: Administrative purpose, billing purpose including compliance with Medicare requirements, follow up reminders/ recalls, disclosure to treating doctors, specialists, and allied health in this practice or outside this practice, for legal related disclosure as required by court of law, for purpose of research only where de-identified information is used.	
Patient Signature	**Date**

Please print clearly – all sections must be completed