NEW PATIENT FORM

cooloola coast general practice

We need this information to provide the best quality care. This form complies with the RACGP *Standards for general practices (5th edition)*. This means your personal health information is kept private and secure, as required by federal and state privacy laws. If you have concerns, please leave blank and discuss with your GP. Please notify us promptly of any changes in your contact details. Accurate contact details help us identify you and your medical records, and allow us to contact you promptly about tests and results.

Please print letters
Use black or blue pen
Place a tick or X in applicable boxes

Section A: **Personal details**

Title ..... Surname ..... Given names .....

Date of birth ..... Gender ..... Marital status ☐ Single ☐ Married ☐ Defacto ☐ Widowed

Are you of Aboriginal or Torres Strait Islander origin?

☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Both (A&TSI

Country of birth ..... Interpreter required? ☐ Yes ☐ No Please specify language .....

Home address ..... Postcode .....

Postal address ..... Postcode .....

Telephone number ..... Work number ..... Mobile number .....

Preferred contact number ☐ ☐ ☐

Email .....

Medicare card number ..... Ref number ..... Expiry date .....

Pension, Health Care Card or Veteran's Affairs number ..... Card colour ..... Expiry date .....

Private health insurance company ..... Membership number .....

Section B: **Consent**

Our practice uses a reminder system to help you maintain your health. The practice sends reminders by post, email, telephone or SMS for appointments and procedures such as vaccines, Pap tests and other health reviews.

I consent to being contacted with reminders to help me maintain my health ☐ Yes ☐ No

Our practice also sends information to the Australian Childhood Immunisation Register and Pap Smear Register. These registers also send reminders, which can be helpful if you move address.

I consent to being contacted with reminders to help me maintain my health ☐ Yes ☐ No

Please continue over the page

Section C: **Next of kin/Emergency contact**

Next of kin name ..... Relationship to you .....

Telephone number ..... Work number ..... Mobile number .....

Emergency contact (if different to above) name ..... Relationship to you .....

Telephone number ..... Work number ..... Mobile number .....

Section D: **Allergies and medicines**

List all allergies and intolerances to medications ..... Describe your reaction .....

....

....

....

List regular medications and doses ..... Health issues/Operations .....

....

....

....

Family health history

....

....

....

....

Do you have an advance care directive for end of life care? ☐ Yes ☐ No

For more information talk to your Doctor

Please see our Admin staff for information on how we can transfer records from your previous Doctor.

Signature of patient or guardian (please specify if guardian)

Today's date

Please advise us if your contact information or Medicare details change.