GEELONG MEDICAL & HEALTH GROUP

NEW PATIENT INFORMATION FORM

Any information is strictly private and confidential.

TITLE	Mr Mrs Ms Miss Mast Other ……		Sex : Male ☐ Female ☐
FULL NAME			
DATE OF BIRTH	/ /		
ADDRESS	Full address:		
PHONE NUMBERS	Home:	Work:	Mobile:
EMAIL			
MEDICARE CARD		Ref:	Exp.
DVA NUMBER		TYPE: ☐ Gold ☐ White EXP Date.-	
PENSION/HEALTHCARE CARD	CRN: Exp.		
PRIVATE HEALTH INSURANCE	Company: Number:		
NEXT OF KIN/EMERGENCY CONTACT (who can we contact in an emergency) Name: Phone: Relationship to you:			
Country born in? (ethnicity)		Language Spoken	
To assist with health initiatives - are you Aboriginal and/or Torres Strait Islander?	Aboriginal ☐ Torres Strait Islander ☐ Both ☐ None ☐		
Do you require a translator?	No ☐ Yes ☐ Language Spoken:		
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…….		
PAST ALCOHOL INTAKE	☐ NIL ☐ Occasionally ☐ Moderate ☐ Heavy		
ALLERGIES *Are you sensitive to anything? Food, medications, dressings etc.)	☐ No ☐ Yes, (Please list)		

I, (Name) …… (Patient / Parent / Guardian)

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 Laminated Practice Information Sheet underneath. 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.

I consent to receive sms message and email correspondence. (We use this information for sending sms reminders and urgent health updates etc. Please note that you may revoke your permission at any time).

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

Please note: By signing this form you are agreeing to our policies and procedures outlined in the laminated sheet attached.

…… (Signature) Date ……/……/…….