New Patient Form

We need this formation to provide the best quality care. Our practice follows the guidelines of The Royal Australian College of General Practitioners Handbook for the management of health information in private medical practice. 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. This form complies with the RACGP Standards for general practices.

Patient's details

Title: _____ Surname: _____ Given Names: _____

Date of birth: ___/___/___ Gender (please circle): Male Female Transgender

Do you identify as: He She Them Other (please circle)

Marital Status: Single Married Partner Separated Divorced Widowed

Medicare No. _____ Ref No.__ Exp Date_____

Pension, Health Care Card or Veterans Affairs Number (if applicable) _____ Exp Date_____

Occupation: _____ Employer: _____

Home Address: _____

Postal Address: _____Email: _____

Phone: Home _____ Work _____ Mobile _____

Next of Kin

Name _____ Relationship to you _____

Phone: Home _____ Work _____ Mobile _____

Emergency Contact (if different to above)

Name _____ Relationship to you _____

Phone: Home _____ Work _____ Mobile _____

Country of birth _____ If applicable year of arrival in Australia? _____

What is your primary language? _____ Do you require an interpreter? ☐ Yes ☐ No

Are you Aboriginal or Torres Strait Islander?

☐ NO ☐ Yes - Aboriginal ☐ Yes - Torres Strait Islander ☐ Yes - Aboriginal & Torres Strait Islander

If YES, would you like to register for the Closing the Gap (CTG) Pharmaceutical Benefits Scheme (PBS) co-payment?

☐ Yes ☐ No

List allergies & intolerances to medications _____

_____

List regular medications and doses & over the counter medications and doses _____

_____

Smoking ☐Yes Number per day: Vaping ☐Yes ☐ Never Smoked / Vaped ☐ Ex-Smoker / Vaper – Year Vaping Quit:_____

PLEASE TURN OVER

Our practice undertakes research, professional development, and quality assurance/improvement activities to improve patient care. All people accessing personal health information for this purpose have signed a written confidentiality agreement.

Our practice uses a recall system to improve the quality of your health care. The practice sends recall letters for procedures such as vaccinations, pap smears and other health reviews.

I consent to my ***appointment*** being sent by secure SMS / text message ☐ Yes ☐ No

I consent to my ***recall reminders*** being sent by secure SMS / text message ☐ Yes ☐ No

I consent to being contacted with recall letters. ☐ Yes ☐ No

I consent to the practice leaving messages identifying George Town Medical Centre as the caller ☐ Yes ☐ No

I understand there will be a non-attendance fee or $44 if I do not attend the appointment and I cannot book another appointment until that fee is paid. ☐ Yes

Signature of patient or guardian _____ Date ___ / ___/ ___

If you wish for your Spouse/Partner/Parent/Carer/Adult Child to be given your test results and or appointment times and or other medical information please fill in our Authority to Release Information Form.

Transfer of Health Information

You may have consistently consulted with a GP at another practice. The health information held by that GP may assist us with your future health care needs. You may wish to have a copy or a summary of your health records transferred to this practice. Please ask the receptionist for information about how this can take place.

Please fill in this section only if other family members will be attending this Practice.

	Name	Date of Birth	Relationship	Allergies
1				
2				
3				
4				
5				
6				