BRIBIE DOCTORS
New Patient Details Registration Form

TITLE: MR/MRS/MISS/MS/MASTER SURNAME: _____

FIRST NAME: _____ MIDDLE NAME: _____

KNOWN AS: _____DOB: _____GENDER:

MEDICARE NUMBER: _____ EXPIRY DATE: _____ REF: _____

ARE YOU THE HOLDER OF A CURRENT DVA/PENSION OR HEALTH CARE CARD: YES/NO (Please circle one)

PENSION/DVA/HCC NUMBER: _____ EXPIRY DATE: _____
(COMMONWEALTH SENIORS HCC)

COUNTRY OF BIRTH (If not born in Australia) _____

REGULAR PHARMACY _____

Do you identify as: ABORIGINAL/TORRES STRAIT ISLANDER/ABORIGINAL AND TORREST STRAIT ISLANDER

CTG (Cover the Gap Registration Number): _____

ADDRESS: _____

SUBURB: _____ STATE: _____ POSTCODE: _____

PHONE: home: _____ mobile: _____ _____work: _____

POSTAL ADDRESS: (if different from above address) _____

SURBURB: _____ STATE: _____ POSTCODE: _____

EMAIL: _____

OCCUPATION: _____ MARITAL STATUS: _____

NEXT OF KIN: _____RELATIONSHIP TO YOU: _____

NOK PHONE home: _____ mobile: _____ work: _____

EMERGENCY CONTACT: _____ RELATIONSHIP TO YOU: _____
(if different from next of kin)

PHONE: home: _____ mobile: _____ work: _____

Do you consent to Bribie Doctors identifying ourselves, when contacting or leaving messages for you by telephone? Yes/No (Please circle one)

Do you consent to Bribie Doctors using SMS messages to contact you? Yes/No

We value your privacy. All information provided about you is kept in the strictest confidence and we operate in accordance with the Privacy Act (2009) and Privacy Amendment (Enhancing Privacy Protection) Act 2012. We are committed to protecting your privacy and ask for your consent for the use and disclosure of your personal health information as required during your health care.

I give my permission for my personal health information to be collected, used and disclosed as required during my health care. I understand I am free to withdraw, alter or restrict my consent at any time by notifying this practice in writing

Signature: _____

HOW DID YOU HEAR ABOUT US? NEWSPAPER/ NEIGHBOURHOOD WATCH NEWSLETTER / WORD OF MOUTH/YELLOW PAGES/OTHER (Please specify) _____

BRIBIE DOCTORS MEDICAL HISTORY FORM

SURNAME: _____
GIVEN NAMES: _____
DOB: _____

Allergies – Drug and Reaction:

_____
_____
_____
_____

Current Medications – Drug Name and Strength / Frequency (Including over the counter & natural/herbal treatments

_____
_____
_____
_____
_____

Family Medical History:
(Please list any family history of disease, health concerns or chronic conditions)

Mother: _____
_____
Father: _____
_____
Siblings:_____
_____

Current Treating Specialists (and treating condition)

_____
_____
_____
_____

Previous GP (name and clinic):

_____
_____

Social History: Living alone /or with family/friends (please list all members of household)

_____
_____
_____

Smoking: YES/NO
If yes how many per day _____
If Ex Smoker quit date: _____

Alcohol: YES/NO
If yes, number of days/week you drink alcohol: _____
If yes, number of std drinks drank in a day: _____

Past Medical History/Operations/Procedures:
(please list any medical history, operations etc. and the year they occurred, below)

Year	Condition

Immunisations:
(Please include date of last flu, pneumonia and tetanus vaccine, if known)

Vaccination	Year

WOMEN ONLY:
Date of last Pap Smear (If applicable):
Any abnormal result in past: YES/NO

Date of last Mammogram (If applicable): Any abnormal result in past: YES/NO

Our practice may use a reminder system to help you maintain your health. The practice may send reminders by post, email, telephone or SMS for procedures such as vaccinations, 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. Please advise us if your contact information for Medicare details change. I consent to being contacted with reminders to help me maintain my health

I consent to being contacted with reminders to help me maintain my health

YES / NO

Signed by Patient _____