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

Marital Status: Single Married Defacto Separated Divorced Widowed

Medicare No. _____ Ref No.___ Exp.Date _____ Private Health Fund Yes No

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

Occupation _____ Employer _____

Home Address _____

Postal Address _____

Phone (home) _____ (work) _____ Mobile _____

Emergency contact

Name _____ Relationship to you _____

Phone (home) _____ (work) _____ Mobile _____

Australia is a genuinely multicultural society. To tailor appropriate care, encourage understanding and appreciation between people from different nationalities and backgrounds –Do you identify as someone from a culturally and/or linguistic diverse background?

☐ Yes - Please indicate ethnicity……

To assist with health initiatives - are you Aboriginal or Torres Strait Islander?

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

List allergies & intolerances to medications _____

_____

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

Smoking Yes (Number per day) No Year quit_____ (if applicable)

134 Waterloo Rd, Greenacre, NSW, 2190
Phone: (02) 8766 3300 info@greenmed.com.au Fax: (02) 8208 9874

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.

I consent to my health record being reviewed as a part of the quality improvement activities in this practice. Yes No

Our practice uses a reminder system to improve the quality of your health care. The practice sends reminders by mail or telephone for procedures such as vaccinations, pap smears and other health reviews.

I consent to being contacted with reminders. Yes No

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

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

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.

Other Family Members

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

Staff Only	Name of Staff	Chart No.	Date & time:

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