Surfcoast Medical Centre

NEW PATIENT INFORMATION SHEET

Thank you for spending a few minutes to complete this form regarding your personal details and medical history. This information is important to ensure a high level of medical care. We respect your privacy and all information provided remains confidential as per the Information Privacy Act (2000).

Title: Mr/Mrs/Miss/Ms/Dr/Prof/ other: _____
Surname: _____ Given Names: _____ Preferred Name: _____
Date of Birth: _____ Gender: Male / Female

Residential address:
Street: _____
Suburb: _____ Postcode: _____
Home phone: _____ Workphone : _____ Mobile: _____

Postal address as held by Medicare if different from above:
Street_____
Suburb: _____ Postcode: _____

Are you of Aboriginal, Torres Strait Islander or other cultural background origin? Yes ☐ No ☐
Aboriginal / Yes, Torres Strait Islander / Yes, other cultural background_____

Medicare No: _ _ _ _ - _ _ _ _ _ - _ Ref _ (number beside your name) Exp date: ____/_____

Pension/ Health Care Card No (if applicable): _ _ _ - _ _ _ - _ _ _ _ Exp date: ___/____/___ (Please show staff)

Veterans Affairs No: (if applicable) _____ Colour of Card_____

Person responsible for the account: _____ DOB:_____
Medicare No: _ _ _ _ - _ _ _ _ _ - _ Ref _ (number beside payers name) Exp date: ____/_____

Is your condition related to a Workcover or TAC Claim? Yes ☐ No ☐ №:_____

Next of Kin/Emergency contact: _____ Relationship: _____
Contact number: _____
Information to be conveyed to Next of Kin: All / None / As outlined: _____

Information for the Doctor.
Occupation: _____

Medical History: _____
_____
_____

Known allergies: Yes ☐ No ☐. If yes: _____

Current Medications: _____
_____

Family Medical History (eg. Diabetes, Heart disease, Asthma, Cancer):
_____
_____

Do you smoke cigarettes? Yes ☐ No ☐ How many per day_____
Do you drink alcohol? Yes ☐ No ☐ How Often? _____ On a Day, how many std drinks: _____

Do you consent to SMS reminders for appointments, clinical reminders, clinical communication (which may include results or clinical messages such as recalls) and health awareness? Yes ☐ No ☐
*Please be aware that when disabling your consent, you are also disabling consent for appointment reminders.

Other doctors who may be treating you: _____
I certify that the above information is correct. In signing below, you agree to our Privacy Policy on the collection of your personal information and in the event of a debt you agree to pay any commission generated on the debt collected on your behalf by our nominated debt collection agency.

Signature: _____ Date: ___/_____/___