NEW PATIENT INFORMATION FORM

Could you please assist us by completing the following?

MOOREBANK
FAMILY MEDICAL PRACTICE

Title: ☐ Dr ☐ Mr ☐ Mrs ☐ Ms ☐ Miss

First Name: _____ DOB: _____

Middle Name: _____ Last Name: _____

Street Address: _____

Suburb & Postcode: _____

Mobile No: _____ Home No: _____ Work No: _____

Email: _____

Medicare Number: _____ Ref No: _____ Expiry: _____

Healthcare/ Pension/DVA Gold/White No: _____ Expiry: _____

Are you:

☐ Aboriginal ☐ Torres Strait Islander origin ☐ Neither

Cultural or ethnic background: _____

Next of Kin (Name) M / F: _____

Relationship: _____ Number: _____

Emergency Contact (Name) M / F: _____

Relationship: _____ Number: _____

REMINDER/ RECALL SYSTEM: If we need to contact you what is your preferred method of contact:

☐ Phone ☐ Mail ☐ Email

Allergies: _____

Current Medications: _____

Family History- Any of your family members had? Diabetes, asthma, heart disease, mental illness, cancer etc.

_____

Social History:

Tobacco: _____ day/week Starting date: _____ Ceased smoking date: _____

Alcohol: _____ day/ week/ month (standard drinks)

Do you consent for your medical information uploaded & ongoing onto:

☐ My Health Records ☐ iRAD ☐ Neither

Your medical record will be accessed by relevant health care providers at MFMP for the purpose of providing you quality health care. MFMP participates in QI & research to improve the quality of care provided to you and your family, the information collected, used and stored remains anonymous to comply with the Australian Privacy Principals contained by the Privacy Act 1998 (Cwth).

Patient Signature: _____ Date: _____

Parent/ Guardian Signature: _____ Date: _____