New Patient Registration Form

Bremer Medical Centre

Please notify us promptly of any changes in your contact details. Accurate details will help us to follow-up.Reviewed February 2022

Title: ___ Family Name: _____ Given Name: _____Preferred Name: _____Date of Birth: ___/____/_____

Birth Sex: Male ☐ Female ☐ Other **Gender Identity: ☐ Male ☐ Female ☐ Non-Binary ☐ Gender Diverse ☐ Transgender ☐ Different Identity**

Knowing your cultural background can help us provide healthcare that meets your individual needs.
Are you of Aboriginal or Torres Strait Islander origin?
☐ NO ☐ Yes Aboriginal ☐ Yes Torres Strait Islander ☐ Yes, both Aboriginal and Torres Strait islander

Other cultural background (e.g. Mediterranean, Asian, African): **Country of Birth: _____**

Is English your first language? YES☐ NO☐ **If not, do you require an interpreter? YES☐ NO☐** **Interpreter Language Required: _____**

Street Address: _____Suburb: _____ Post Code: _____State: _____

Postal Address:☐ Same as above ☐ Different:_____

Home Phone:_____ Work Phone: _____ **Mobile: _____ Email:_____**

Occupation: _____

Consent

Our practice participates in National, State or Territory Reminder System. The practice sends recalls and reminders by post, email, phone or SMS.

Do you consent to receive the electronic communications regarding Appointments, Reminders, Clinical Communication and Health Awareness? ☐ YES ☐ NO

Please advise the receptionist if you wish to opt out from any electronic communication.

Medicare Card Number: _____ Reference Number:_____ Expiry Date:

Pensioner Concession Card Number:_____ Expiry Date:

Health Care Card Number: _____ Expiry Date:

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DVA ☐ **GOLD** ☐ **WHITE** **Expiry Date:**

Next of Kin

First Name: Last Name: Phone: Relationship to you:

Emergency Contact

Tick if emergency contact is same as above ☐ **YES** ☐ **NO (If No, please fill in below)**

First Name: Last Name: phone: Relationship to you:

Do you give Bremer Medical Centre permission to contact the NOK or Emergency Contact if we cannot reach you in the case of an emergency? ☐ **YES** ☐ **NO**

Declaration

I hereby consent to be a patient at Bremer Medical Centre and confirm that I agree to adhere to practice policies and procedures.

Signature of patient or guardian: _____ Date**:**

Our Practice collects personal information and sensitive health information about you and safeguards its confidentiality and privacy in accordance with National Privacy Principles. UQ Health Care's Privacy Policy is available on request. This form complies with the RACGP Standards for general practices (5th edition). 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.

Allergies- Do you have any allergies or are you allergic to some medicine or dressings

☐ _____ Describe the reaction _____

☐ _____ Describe the reaction _____

Social History

☐ Tobacco: _____ day/week or ceased smoking. Date if known_____ ☐ Non-Smoker

☐ Alcohol: _____day/week/month or _____ drinks /day (circle appropriate) ☐ Non Drinker

Your Health History

Do you have or had history of

☐ Asthma ☐ Diabetic ☐ Hypertension ☐ Heart Disease ☐ Chronic Illness

☐ Operation _____

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☐ Other _____