New patient registration form

Bremer Medical Centre
BY UQ HEALTH CARE

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

Title: ____ Family name: _____ Given name: _____ Preferred name: _____

Date of birth: ____ / ____ / ____ Birth sex: ☐Female ☐Male ☐Intersex

Gender identity: ☐Man ☐Woman ☐Non-binary ☐Transgender ☐Other: _____

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 Straight Islander

Other cultural background: _____ 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: _____ Postcode: _____ 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 number: _____ Reference number: _____ Expiry date: _____

Pensioner concession card number: _____ Expiry date: _____

Health care card number: _____ Expiry date: _____

DVA: ☐Gold ☐White Expiry date: _____

Next of kin

First name: _____ Last name: _____ Phone: _____ Relationship to you: _____

Emergency contact

Is your emergency contact the same as above? ☐ YES ☐ NO (If no, please fill out the below)

First name: _____ Last name: _____ Phone: _____ Relationship to you: _____

Do you give Bremer Medical Centre permission to contact your next of kin 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.

Your/parent/guardian signature: _____ 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 any medicine or dressings? ☐ YES ☐ NO

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Social history:

☐ Smoker ☐ Non-smoker

Tobacco/nicotine type: _____ Amount per ☐ day/☐ week/☐ month: _____ OR date ceased smoking: _____

☐ Drinker ☐ Non-drinker Alcohol amount per ☐ day/☐ week/☐ month: _____

Your health history:

Do you have, or have a history of:

☐ Asthma ☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Chronic Illness ☐ Operation

Other/comments: _____