

DOCTORS @ CAPALABA CENTRAL
NEW PATIENT FORM



Doctors @ Capalaba
CENTRAL

**** Please return this form to Reception along with your Medicare card ****

Title: _____ Given Names: _____ Surname: _____

Preferred Name (if applicable): _____ DOB: ____/____/____ Gender: _____

Address: _____ Suburb: _____ Postcode: _____

Mobile: _____ Home: _____ Email: _____

Occupation: _____ Country of Birth: _____ Marital Status: _____

Do you identify as Aboriginal? **Yes/No** Do you identify as Torres Strait Islander? **Yes/No**

Medicare No: _____ Reference No: _____ Expiry: ____/____/____

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

Emergency Contact Name: _____ Phone: _____ Relationship: _____

Do you drink alcohol? **Yes/No** – How many drinks per day? _____ How many days per week? _____

Do you smoke? **Yes/No** – How many per day? _____

Do you have any allergies? **Yes/No/Unknown** – if yes, please list with type of reaction:

Please list any current medications you are taking including over the counter and vitamins:

PERSONAL MEDICAL HISTORY (please circle if any of the following conditions are applicable to you)

Heart Disease/ Attack	Stroke	Breathing Problems	Psychiatric Disorder	Blood Pressure
Bleeding Disorder	Cancer	Diabetes	Genetic Disorder	Orthopaedic

FAMILY MEDICAL HISTORY (please circle and provide family member)

Heart disease/Attack _____	Blood Pressure _____	Breathing Problems _____
Diabetes _____	Bleeding Disorder _____	Cancer _____
Psychiatric Disorder _____	Genetic Disorder _____	

How did you hear about this practice? (please circle) Google, Facebook, Word of Mouth, Instagram, other.

This practice uses secured SMS to notify our patients with health messages, reminders, review appointments required and vaccinations. If you do not have a mobile device we will make contact with you via the numbers you provide.

If you are unable to attend an appointment, please contact us as soon as possible as this practice does have a Non Attendance Policy. Non-Attendance without a valid reason will attract a **\$30 fee**. Thank you

I acknowledge I understand the Non Attendance Policy. **Yes/No**

In compliance with the Privacy Act, we require your consent for the treating Doctors to use the information provided on this form. This and additional information may be provided to other Doctors and/or Specialists when requesting medical imaging, pathology, referrals etc. Patient information will not be released to family members without the patient's written consent. Doctors and staff will not discuss test results over the phone. It is your responsibility to arrange a follow up appointment to discuss your results. Occasionally your consult may include the presence of a medical student or GP Registrar as our doctors are actively engaged in teaching training doctors. All persons accessing your personal health information are bound by confidentiality. Please do **NOT** hesitate to discuss any concerns, questions or complaints about any issues related to the privacy of your personal information with your doctor.

Signature of Patient or Guardian: _____ Date: ____/____/____