

New Patient Information Form

We are committed to providing our patients with the best care.
To do this, it is essential that your personal information is up to date and accurate.

Bligh Park Family Practice
blighparkgp@gmail.com

SURNAME	* MISS	* MS	* MRS	* MR	* DR
FIRST NAME					
DATE OF BIRTH					
MEDICARE NUMBER	Ref No.	Expiry Date			
*DVA Gold / White (Please Circle)		Expiry Date			
* CONCESSION CARD eg: Pension/HCC/Seniors HCC	Ref No.	Expiry Date			
RESIDENTIAL ADDRESS					
POSTAL ADDRESS					
MOBILE PHONE			HOME PHONE		
EMAIL ADDRESS					
MARITAL STATUS					
OCCUPATION					
COUNTRY OF BIRTH			ETHNIC BACKGROUND		

<i>DETAILS OF YOUR NEXT OF KIN</i>	<i>DETAILS OF YOUR EMERGENCY CONTACT</i>
* NAME D.O.B _____	* NAME D.O.B _____
* RELATIONSHIP TO PATIENT	* RELATIONSHIP TO PATIENT
* ADDRESS	* ADDRESS
* PHONE NUMBER (H) (M)	* PHONE NUMBER (H) (M)

DO YOU IDENTIFY AS BEING:

Aboriginal ? Yes No
 Torres Strait Islander ? Yes No
 Other Cultural Group (Please state) _____

CONSENT

I give consent and understand the reasons why my information must be collected, and the purposes for which my information may be used or disclosed. I understand that if my information is to be used for any purpose other than that set out, my further consent will be obtained. I also give permission for my personal information to be collected, used and disclosed as described above, including contact via SMS to my mobile phone number. I understand only my relevant personal information will be provided to allow the above actions to be undertaken and I am free to withdraw, alter or restrict my consent at any time by notifying this practice in writing.
 This information may be shared with other providers involved your care. Our Privacy Policy is available at reception

Signature: _____ Date: _____

If not patient signing - your name (please print) _____

Your relationship to patient (e.g. Mother, Father, guardian) _____

How did you hear about us (Please circle)

Internet Letterbox Drop Word of mouth Advertising Current patient Photo ID checked by staff

Medical Information Form

Bligh Park Family Practice

CONTACT INFORMATION

Full name:		Date of Birth:	
Email:		Ethnic Background:	

YOUR HEALTH INFORMATION

Allergies: Do you have any allergies or are you sensitive to drugs or dressings?

No Yes – details: _____

Smoking:

Non-smoker

Ex-Smoker

No. of cigarettes _____

Year commenced _____

Year Quit _____

Smoker

Frequency: daily Weekly

less than weekly

Year started _____

No. of cigarettes _____

Alcohol:

1. How often do you have a drink containing alcohol?

Never 4 or more time a week 2-4 times a month

2-3 a week Monthly or less

2. How many standard drinks containing alcohol would you have on a typical day?

1 or 2 3 or 4 5 or 6

7 to 9 10 or more

3. How often do you have 6 or more drinks on one occasion?

Never Less than monthly Monthly

Weekly Daily or almost daily

Physical Activity:

How many times a week do you do 20 minutes of vigorous physical activity that makes you sweat/puff/pant? _____

How many times a week do you usually do 30 minutes of brisk walking or moderate physical activity that increases your heart rate or makes you breathe harder than normal? _____

Do any members of your family have:

Please state your family relationship: i.e. mother, father, brother, sister, aunt, uncle, etc

Asthma _____

Diabetes _____

High Blood Pressure _____

Heart Disease _____

Mental Illness _____

Cancer - _____

Type: _____