Date _____

NEW PATIENT FORM

THE Lockyer DOCTORS
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TITLE _____

FAMILY NAME _____

GIVEN NAME _____ **MIDDLE NAME** _____

PREF. NAME _____

DATE OF BIRTH _____

BIRTH SEX _____

BIRTH SEX _____ **GENDER INDENTITY** _____

PRONOUNS She, Her, Hers / He, Him, His / They, Them, Theirs

ATSI. STATUS Australian Non Indigenous / Aboriginal / Torres Strait Islander

BIRTH COUNTRY _____

ADDRESS _____

_____

POST. ADDRESS _____

HOME PH _____ **WORK PH** _____

MOBILE _____

*** Our Email is Unsecured – Do you consent to Email YES / NO**

EMAIL _____

MEDICARE NO: _____ **Ref [ ]** **Exp** _____

PENSION NO: _____ **Exp** _____

PENSION TYPE _____

DVA NO: _____ **Type** _____

PRIV HEALTH FUND _____ **Member No** _____

RELIGION _____

NEXT OF KIN NAME _____ **DOB:** _____

Relationship to Patient _____

Phone _____

Address _____

EMERG CONTACT _____ **DOB:** _____

Relationship to Patient _____

Phone _____

Address _____

PATIENT OCCUPATION _____

PREF. CONTACT VIA PHONE SMS LETTER

PLEASE NOTE – Referrals to medical specialist/hospitals require patient information to be current and correct. If your details are not up to date there may be a delay in the referral process. Please take time to complete the following to ensure prompt response.

DO YOU HAVE ALLERGIES? YES [ ] NO [ ] _____ **REACTION**_____

ADVERSE REACTION TO MEDICATIONS? YES [ ] NO [ ] _____ **REACTION**_____

DO YOU SMOKE? YES [ ] NO [ ] **AMT / DAY**_____ **HOW LONG HAVE YOU SMOKED** _____

HAVE YOU PREVIOUSLY SMOKED? YES [ ] NO [ ] **DATE / YEAR CESSATION (Quitting)**_____

LAST QUIT ATTEMPT **YEAR**_____ **LONGEST PERIOD OF ABSTINENCE** _____

DO YOU CONSUME ALCOHOL? YES [ ] NO [ ] _____

HOW OFTEN DO YOU CONSUME ALCOHOL? _____

HOW MANY STANDARD DRINKS DO YOU CONSUME PER OCCASION? _____

HOW OFTEN DO YOU HAVE MORE THAN 6 DRINKS ON ONE OCCASION? _____

DO YOU HAVE A CONCERN ABOUT YOUR ALCOHOL INTAKE? YES [ ] NO [ ]

DO YOU LIVE ALONE? YES [ ] NO [ ] IF NO, WHO DO YOU LIVE WITH? _____

DO YOU HAVE CHILDREN? YES [ ] NO [ ] HOW MANY & WHAT AGES? _____

ARE YOU PHYSICALLY ACTIVE? YES [ ] NO [ ] IF YES, WHAT TYPE OF ACTIVITY? _____

WHAT ARE YOUR HOBBIES/INTEREST? _____

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS? (Please circle)

Diabetes / Asthma / Heart Problems / High Blood Pressure / Stroke / Breast Cancer / Bowel Cancer / PVD (Vascular Disease) / Bleeding Disorders / Blood Clots

DOES ANYONE IN YOUR FAMILY SUFFER FROM ABOVE? (Indicate Relationship) _____

DO YOU HAVE ANY SURGICAL HISTORY? _____

NEW PATIENT CONSENT

The Lockyer Doctors have a legal & ethical duty to protect patient information under The Privacy Act 1988.

CONSENT FOR USE & DISCLOSURE OF PERSONAL HEALTH INFORMATION – I consent to the use of my personal health information by **The Lockyer Doctors** and other health providers involved in my medical treatment & health care. I consent to the disclosure of my personal health information by **The Lockyer Doctors** to other health providers, directly or indirectly involved in my personal health care or medical treatment. I understand that the doctors within the practice are General Practitioners.

NAME _____ SIGNATURE _____ DATE _____

OFFICE USE ONLY

PATIENT ID _____ Reception _____ Nurse _____

PHOTO ID CHECKED Y [ ] N [ ] Initial _____