THE Lockyer DOCTORS
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NEW PATIENT FORM

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 the time to complete the following to ensure a prompt response.

Section 1. Personal Information	
Title ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Other:	**Family Name**
Given Names (First, Middle)	**Preferred Name**
Date of Birth	**Birth Sex** ☐ Male ☐ Female
Country of Birth	**Gender Identity** ☐ Male ☐ Female ☐ Non-binary ☐ Other Pronouns: ☐ He, Him, His ☐ She, Her, Hers ☐ They, Them, Theirs
Ethnicity ☐ Aboriginal ☐ Torres Strait Islander ☐ Australian Non Indigenous ☐ Other:	**Preferred Language** ☐ Interpreter required
Occupation	**Religion**

Section 2. Contact Information	
Home Address	**Postal Address**
Home Phone	**Work Phone**
Mobile	**Email Address**
Preferred Contact Via ☐ Phone ☐ SMS ☐ Letter	**Email Consent** Our email is unsecured – Do you consent to email? ☐ Yes ☐ No
Next of Kin	
Name	**Address**
Relationship to Patient	**Phone**
Emergency Contact	
Name	**Address**
Relationship to Patient	**Phone**

Section 3. Medicare and Billing

Medicare No.	**Individual Ref No.**	**Expiry**
Pension No.	**Pension Type** ☐ Pension ☐ Healthcare Card ☐ Commonwealth Seniors Health	**Expiry**
DVA Number	**DVA Type** ☐ Gold ☐ Orange ☐ White - Conditions specified:	
Private Health Fund	**Member No.**	**Expiry**

Section 4. Health and Lifestyle

Do you have allergies? ☐ Yes ☐ No Reaction:	**Adverse reaction to medications?** ☐ Yes ☐ No Reaction:
Do you smoke? ☐ Yes ☐ No If yes, amount per day: How long have you smoked? Last quit attempt (year): Longest period of abstinence:	**Have you previously smoked?** ☐ Yes ☐ No Date / year cessation (quit):
Do you consume alcohol? ☐ Yes ☐ No If yes, how often do you consume alcohol? How many standard drinks per occasion?	**Are you concerned about your alcohol intake?** ☐ Yes ☐ No How often do you have more than 6 drinks on one occasion?
Do you live alone? ☐ Yes ☐ No If no, who do you live with?	**Do you have children?** ☐ Yes ☐ No If yes, how many and what ages?
Are you physically active? ☐ Yes ☐ No If yes, what type of activity?	**What are your hobbies/interests?**
Do you have any of the following conditions? ☐ 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 any of these conditions?** (Indicate relationship):
Do you have any surgical history?	

Section 5. Patient Consent

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

CONSENT FOR USE AND 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 and 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
Health Identifier verified	Date	Date
Photo ID checked ☐ Yes ☐ No	Initial	