New patient registration form





BY UQ HEALTH CARE

Title: Family name:	Given name	e:	Preferr	ed name:	
Date of birth:/ Birth sex:	Female	Male Inter	sex		
Gender identity: Man Woman	Non-binary	Transgender	Other: _		
Knowing your cultural background can help Islander origin? No Yes, Aborigina				needs. Are you of Abor poriginal and Torres Strai	
Other cultural background: Is English your first language? Yes				Yes No	
Interpreter language required:					
Street address:	Suburb:	Po	stcode:	State:	
Postal address: Same as above	oifferent:				
Home phone: Work pho	one:	Mobile: _			
Email: Occup	oation:				
Consent					
Our practice participates in National, State of SMS. Do you consent to receive the electr Health Awareness? YES NO Please advise the receptionist if you wish to	onic communicat	ions regarding	Appointments		
Medicare number:	Reference numbe	er: Expiry	date:		
Pensioner concession card number:		Expiry dat	e:	-	
Health care card number:	E	xpiry date:			
DVA: Gold White Expiry date:					

Next of kin				
First name:	Last name:	Phone:	Relationship to you	:
Emergency con	tact			
Is your emerge	ncy contact the same as above?	YES NO (If no	o, please fill out the below)	
First name:	Last name:	Phone:	Relationship to you:	
Do you give Broan emergency?	emer Medical Centre permission to YES NO	contact your next of ki	n or emergency contact if we can	not reach you in the case of
<u>Declaration</u>				
I hereby consen	t to be a patient at Bremer Medical (Centre and confirm that	agree to adhere to practice policie	es and procedures.
Your/parent/gu	ardian signature:	Date: / _	_/	
accordance with Standards for ge privacy laws. If y	llects personal information and sensing National Privacy Principles. UQ Head eneral practices (5th edition). Your population you have concerns, please leave blang you have any allergies or are you al	alth Care's Privacy Policy ersonal health information k and discuss with your	is available on request. This form con is kept private and secure, as rec GP.	complies with the RACGP
Sat = #852	Reaction:		_	
	Reaction:			
Allergy:	Reaction:			<u> </u>
Social history:				
Smoker	Non-smoker			
Tobacco/nicoti	ne type: Amount p	er day/week/month:	OR date ceased smoking:	:
Drinker	Non-drinker Alcohol amount	per day/week/month: _		
Your health his	tory:			
Do you have, or	r have a history of:			
Asthma	Diabetes Hypertensio	n Heart Disease	Chronic Illness	Operation
Other/commen	ts:			