Bremer
Medical Centre
BY UQ HEALTH CARE

New patient registration form

Please notify us promptly of any changes in your contact details. Accurate details will help us to follow-up.

Title: ____ Family name: ______________________ Given name: ___________________ Preferred name: __________________

Date of birth: ____ / ____ / ____ Birth sex: Female Male Intersex

Gender identity: Man Woman Non-binary Other: ________________

Knowing your cultural background can help us provide healthcare that meets your individual needs. **Are you of Aboriginal or Torres Strait Islander origin?** No Yes, Aboriginal Yes, Torres Strait Islander Yes, both Aboriginal and Torres Straight Islander

Other cultural background: ________________ Country of birth: __________________
Is English your first language? Yes No **If not, do you require an interpreter?** Yes No

Interpreter language required: _______________________

Street address: ___________________________ Suburb: _________________ Postcode: ________ State: _______

Postal address: Same as above Different: ____

Home phone: _________________ Work phone: __________________ Mobile: __________________

Email: ___________________________ Occupation: ___________________

Consent

Our practice participates in National, State or Territory Reminder System. The practice sends recalls and reminders by post, email, phone or SMS. **Do you consent to receive the electronic communications regarding Appointments, Reminders, Clinical Communication and Health Awareness?** YES NO
Please advise the receptionist if you wish to opt out from any electronic communication.

Medicare number: _____________________ Reference number: _____ Expiry date: ___________

Pensioner concession card number: __________________________ Expiry date: ___________

Health care card number: _____________________________ Expiry date: ____________

DVA: Gold White Expiry date: ___________

Next of kin

First name: _______________ Last name: __________________ Phone: _______________ Relationship to you: _______________

Emergency contact

Is your emergency contact the same as above? YES NO (If no, please fill out the below)

First name: _____________ Last name: ________________ Phone: ________________ Relationship to you: _________________

Do you give Bremer Medical Centre permission to contact your next of kin or emergency contact if we cannot reach you in the case of an emergency? YES NO

Declaration

I hereby consent to be a patient at Bremer Medical Centre and confirm that I agree to adhere to practice policies and procedures.

Your/parent/guardian signature: ______________________ Date: ___ / ___ / _____

Our Practice collects personal information and sensitive health information about you and safeguards its confidentiality and privacy in accordance with National Privacy Principles. UQ Health Care's Privacy Policy is available on request. This form complies with the RACGP Standards for general practices (5th edition). Your personal health information is kept private and secure, as required by federal and state privacy laws. If you have concerns, please leave blank and discuss with your GP.

Allergies - Do you have any allergies or are you allergic to any medicine or dressings? YES NO

Allergy: _____________________ Reaction: ____

Allergy: _____________________ Reaction: ____

Allergy: _____________________ Reaction: ____

Social history:

Smoker Non-smoker

Tobacco/nicotine type: ______________ Amount per day/week/month: ________ OR date ceased smoking: ______________

Drinker Non-drinker Alcohol amount per day/week/month: _____________

Your health history:

Do you have, or have a history of:

Asthma Diabetes Hypertension Heart Disease Chronic Illness Operation

Other/comments: ____