Tweed Health for Everyone

Adult New Patient Information Form

The following information will assist in the planning and provision of appropriate and improved healthcare and services so that your provider can provide the best care possible.

PLEASE NOTE DRUGS OF DEPENDENCE WILL NOT BE PRESCRIBED ON YOUR INITIAL CONSULTATION

Title: Surname:		Given Name:
Known as:		Date of Birth:
Nationality:	Birth Sex (please circle) M F	Gender Identity:

Do you identify as being: (Please circle)

Aboriginal Origin | Torres Straight Islander Origin | Both Aboriginal and Torres Straight Islander Origin | Neither

Other Cultural Group, please state:

Residential Address: _____

Home Phone:	Work:	Mobile:
Email Address:		

Medicare Number:	Ref Number:	Exp Date:
Pension/Health CC Number (please circle):		Exp Date:
DVA Number:	Gold or White Card (please circle)	

Details of your **NEXT OF KIN**

Name:	Relationship to patient:	
Address:		
Home Phone:	Work:	Mobile:

Details of your **EMERGENCY CONTACT**

Name:	Relationship to patient:	
Address:		
Home Phone:	Work:	Mobile:

PATIENT CONSENT

As a part of preventative health services offered by this practice, your GP will send out follow up reminders and recalls when routine investigations are due. I consent to receive the following via sms/email:

☐ **Appointments reminders**

☐ **Clinical Communication from your GP (results & reminders)**

☐ **Health awareness (Demographic Specific)**

☐ **Consent to email Invoices**

I consent to the use of and the disclosure of my personal health information to any health care provider involved in my medical treatment and health care, including MyHealth Record and de-identified data for research.

By consenting to receive sms reminders I understand that other users of the mobile phone number I have provided may be able to gain access to appointment/clinical reminders sent by Tweed Health

Signature: _____ Date: _____

Name: _____

Allergies

Do you have any allergies or are you sensitive to drugs or dressings? (Please Circle)

NO	YES (please specify)

Medical Conditions (Past and Present) (e.g. cancer, heart disease, diabetes, asthma, melanoma etc.)

Operations (please include the year)

Medications (Current Medications including over the counter medication & Supplements)

Medication	Strength	Quantity per day

Family Medical History (e.g. cancer, heart disease, diabetes, asthma, melanoma etc.)

Social History (please circle)

Alcohol YES/ NO If yes, how many days per week Quantity per day:

Smoker YES / NEVER / EX SMOKER (Year Stopped:)
If you answered yes - how many cigarettes per day do you currently smoke:

Martial Status:	Children:
Occupation:	

Vaccinations

Tetanus	Yes / No	Year:
Influenza	Yes / No	Year:
Pneumococcal	Yes / No	Year: