CHILDERS DOCTORS SURGERY

New Patient Details Form

Title			Sex	Male / Female	
First Name			Surname		
Middle Name (if any)			Date of Birth	____ / ____ / ____	
Address					
	City : State: Postcode:				
Postal address					
Home Phone		Mobile		Work Phone	
Email					
Ethnicity *(Please circle)*	Are you of Aboriginal or Torres Strait Island Background? **NO** **YES** – Aboriginal **YES** – Torres Strait Island **YES** – Both Aboriginal and Torres Strait Island				
Nationality (*For Non-Australian*)					
Medicare Number	_ _ _ _ _ _ _ _ _ _		Concession Card Number	_ _ _ - _ _ _ - _ _ _ _ Pensioner Card / Health Care Card (please circle one)	
Medicare Card Expiry Date	_ _ / _ _ _ _		Concession Card Expiry Date	_ _ / _ _ / _ _ _ _	
Position on Medicare Card	_		DVA Card Number White/Gold	_ _ _ _ _ _ _ _	
			DVA White Card Condition		

Next of Kin Relationship: *E.g. Sister, Partner*	Name:	Address: Phone:	
Emergency Contact Relationship: *E.g. Sister, Partner*	Name:	Address: Phone:	

MY HEALTH RECORD

Have you registered for My Health Record?	**YES / NO**	If you have not registered for My Health Record, the surgery is able to assist you in registering for My Health Record

I, hereby give **consent** for my **Private Health Information** to be **collected, communicated and transferred** (**verbally, electronically or in writing**) by the Health Professionals at Childers Doctors Surgery to other Treating Doctors/Specialists, Hospitals, Imaging Centres, Pathology Centres and Allied Health Providers as required to carry out treatment of my health care or ***uploading to the My Health Record System*** in accordance to the Privacy Act 1998 & Australian Privacy Principle 3.

Signed _____ Date: ____ / ____ / _____

Childers Doctors Surgery

Dr Esteban Mondia
Dr David Pratt
Dr Fiona Watson

3 Ashby Lane
PO Box 322
Childers QLD 4660
Phone: 4126 1635 Fax: 4126 2794

Patient Details: General Practitioner Sheet	Date:

Surname:	**Given Names:**
Date of Birth:	**Occupation:**
Do you believe you work in a high risk environment? eg; Heavy lifting/chemicals YES ☐ NO ☐ **Details:**	
Health Update: If you are FEMALE and aged between 20-65 years, have you had a PAP SMEAR within the last 4 years: **YES** ☐ **NO** ☐ Are you Pregnant / Breastfeeding **YES** ☐ **NO** ☐	
Parents: **Mother: Living:** ☐ **Deceased:** ☐ **Cause of death:** **Father: Living:** ☐ **Deceased:** ☐ **Cause of death:**	

Please indicate if you (or a family member) suffer from any of the following conditions:	
ALLERGIES:	HIGH / LOW BLOOD PRESSURE:
EPILEPSY / FITS	HIGH CHOLESTEROL:
CANCER:	HEART DISEASE:
DEPRESSION/ANXIETY:	KIDNEY DISEASE:
DIABETES: If so what type?	EMPHYSEMA / BRONCHITIS / ASTHMA:
Other:	Any Major operations:

Current Medications and Dosages: (especially Warfarin or Aspirin, include vitamins and non-script items	
Do you smoke cigarettes – YES ☐ NO ☐ If Yes – Year Started . . . . . Number per Day	
Do you consume alcohol – YES ☐ NO ☐ If Yes – Year Started . . . . . Quantity Per Week.	