Office Use Only:

☐ Form Completed

☐ NP

☐ Existing

GSS
GLOVER STREET SURGERY

This information is private and confidential and is for use in your clinical file only. It is a requirement that all files contain this information for accreditation purposes. Please print and give as much detail as possible to assist us to provide quality care.

How did you find out about our surgery?

☐ Word of Mouth ☐ Relatives ☐ Drive/walk past ☐ A frame outside ☐ Website
☐ Yellow pages ☐ White Pages ☐ Leaflets/flyers ☐ School Newsletter ☐ Radio
☐ Bowls Club ☐ Holiday Accom ☐ Pharmacy ☐ Library Card ☐ Other:_____

PATIENT DETAILS

Mr Mrs Ms Miss Dr **Surname:** _____ **Given Name:** _____ **Middle Name:** _____

Date of Birth _____/_____/_____ **Ethnicity:** ☐ Australian ☐ Aboriginal ☐ TSI ☐ ATSI Other _____

Country Of Birth _____

Residential Address: _____ **Town:** _____ **Postcode:** _____

Postal Address: *(if different to home)* _____

Phone: _____ **Mobile:** _____ **Business:** _____

Email Address: _____ **Do you wish to receive electronic newsletters:** ☐ Yes ☐ No

Medicare No: _____ **Ref #** *(next to name)* _____ **Expiry:** _____

Veterans Affairs No: _____ ☐ Gold ☐ White - Condition/s: _____

Pension/Healthcare Card No: _____ **Expiry:** _____

Do you have private health care fund? ☐ Yes ☐ No **Fund Name:** _____ **Fund Number:** _____

Next of Kin: _____ **Relationship:** _____ **Phone:** _____

Emergency Contact: _____ **Relationship:** _____ **Phone:** _____

Current Medications:

_____

Complimentary Medications: *(eg. Multivitamin, fish oil etc)* _____

_____

Do you have any known allergies? ☐ No ☐ Yes: _____

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ De-facto ☐ Widowed ☐ Separated

Recreational Activities: _____ **Are you an Elite Athlete?** ☐ Yes ☐ No

Accommodation: ☐ Own Home ☐ Rental ☐ Relatives Home ☐ Nursing Home ☐ Homeless ☐ Other

Lives with: ☐ Alone ☐ Spouse ☐ Relative/Parents ☐ Friend

Are you a Carer: ☐ Yes ☐ No Do you have a Carer: ☐ Yes ☐ No

If Yes : Carer Name: _____

Address: _____

Contact No: _____

PLEASE TURN OVER

Smoking: Do you smoke? ☐ Yes ☐ No If yes, how many per day ? _____

Past Smoking History: ☐ Nil ☐ Light ☐ Moderate ☐ Heavy ☐ Which year did you stop smoking? _____

Alcohol Consumption: Do you drink alcohol? ☐ Yes ☐ No

If yes, how many standard drinks per day:_____ How many days per week:_____

Past Alcohol Consumption: ☐ Nil ☐ Occasional ☐ Moderate ☐ Heavy

What is your Occupation? _____ ☐ Retired ☐ Child

PATIENT HISTORY

Please list any operations or previous illnesses: _____

_____

Do you know your blood group? ☐ Yes ☐ No **If yes**, what group are you? _____

FEMALE PATIENTS: **Have you ever had a papsmear?** ☐ No ☐ Yes **Month:** _____ **Year:** _____

Are you currently breastfeeding? ☐ No ☐ Yes

FAMILY HISTORY: ☐ Unknown (eg. Adopted) ☐ No significant family history

Mother: Still alive: ☐ Yes ☐ No **If no**, Age at Death:_____ Cause of Death: _____

Diabetes Hypertension Heart Disease Stroke

Colon Cancer Depression Breast Cancer Other Cancer (Please Specify): _____

Father: Still alive: ☐ Yes ☐ No **If no**, Age at Death:_____ Cause of Death: _____

Diabetes Hypertension Heart Disease Stroke

Colon Cancer Depression Breast Cancer Other Cancer (Please Specify): _____

Other **immediate** family member's **significant illness**:

Relationship:_____ Condition:_____

Relationship:_____ Condition:_____

Relationship:_____ Condition:_____

Relationship:_____ Condition:_____

At Glover Street Surgery we strive to provide high quality care, appropriate to meet our clients' health care requirements.

By becoming a patient of Glover Street Surgery and signing this new patient form I agree and consent to the following:

As part of our reminder service we will SMS you appointment reminders for extended, skin and recall appointments

I consent to the use of my personal health information by the Glover Street Surgery and other health care providers involved in my medical treatment and health care within this centre.

I consent to the disclosure of my personal health information by the above named practice to other health care providers involved directly or indirectly involved in my personal health care or medical treatment.

As part of preventative health services offered by this practice, we send out follow up reminders and recalls when routine investigations are due. I consent to receive follow up reminders and recalls to be sent to the above address and/or text message to my mobile phone number.

Please note, if you no longer require your appointment, we would appreciate you calling to cancel so the time may be made available to other patients. Failure to do so, a minimum of 2 hours prior to your appointment, may incur a fee of $50.00 which is not claimable on Medicare.

Signature:_____ **Date:**_____/_____/_____

Printed Name:_____