Pinjarra Doctors
Family Practice, Travel & Skin Clinic
Ph: (08) 95314286

New Patient Information Form

This form can be emailed to reception@pinjarradoctors.com.au to create a file for the first appointment at Pinjarra Doctors

Title

Family Name	**Given Name**	**Middle Name**	**Preferred Name**

Date of Birth dd/mm/yyyy	**Sex**	**Occupation:**

Allergies:	**Reaction:** ☐ Mild ☐ Moderate ☐ Severe	**Regular medication:**

Are you of Aboriginal or Torres Straight Island decent?
☐ Yes, Aboriginal ☐ Yes, Torres Straight Islander ☐ No

Ethnicity/Nationality

Home Address	**Postal Address**
Street No and Name:	
City/Suburb:	City/Suburb:
State:	State:
Postcode:	Postcode:

Home Phone	**Mobile No.**	**Work Phone**	**Do you consent to bulk bill if eligible?** ☐ Yes ☐ No
E-mail address:			

Do you consent to SMS reminders? ☐ **Yes** ☐ **No**

Do you concent to receive electronic clinical communication? ☐ **Yes** ☐ **No**

Medicare No.:	☐ **Pension Concession Card** ☐ Health Care Card ☐ Commonwealth Senior Card	**DVA Card Details:** Colour:	**Private Health Insurance Fund:** Name:
Ref No.:	No.:	No.:	No.:
Expiry:	Expiry:	Expiry:	Expiry:

Do you consent for our GPs and practice staff to access and use your personal information so they can provide you with the best possible healthcare? ☐ **Yes** ☐ **No**

COLLECTION STATEMENT: *Our practice will need to collect your personal information to provide healthcare services to you. Our main purpose for collecting, using, holding and sharing your personal information is to manage your health. We also use it for directly related business activities, such as financial claims and payments, practice audits and accreditation, and business processes (eg staff training).*

Next of Kin	**Emergency Contact**
Title:	Title:
First Name:	First Name:
Surname:	Surname:
Address:	Address:
City/Suburb:	City/Suburb:
Post Code:	Post Code:
Phone Contact:	Phone Contact:
Alternate Contact:	Alternate Contact:
Relationship:	Relationship:

Smoking History	**Alcohol Intake**	**Medical History SELF**	**Family Medical History**
☐ Non smoker ☐ Ex smoker	☐ Non drinker ☐ Ex drinker		
Year started:	Year started:		
Year stopped:	Year stopped:		
☐ Smoker	☐ Drinker		
How many per day?	No of drinks per day?		
Year Started:			

Signature:	**Date:**