**New Patient Form**

Taken by:

**Carlisle GP & Skin Clinic**

Welcome to our practice. We need this information to provide you with the best quality of care.

Patient Details

Title Name Surname

Date of birth / / □ Male □ Female

Medicare Number / Ref No. Expiry date

|  |  |  |
| --- | --- | --- |
| Do you have a | □ Pension card | □Health Care card □ Veteran Affairs card Private Health |
| Card Number |  | Expiry date |

Home address Suburb

Postcode

Phone (H) (W) (M)

Marital Status □ Single □ Married □ Defacto □ Separated □ Divorced □ Widowed

Occupation Country of Birth /Culture Background

EMERGENCY CONTACT DETAILS

Name Relationship to you

Phone (H) (W) (M)

Are you of Aboriginal or Torres Strait Islander origin □ Yes □ No

□ Aboriginal □ Torres Strait Islander □ Aboriginal and Torres Strait Islander

List allergies and intolerances to medications: ...................................................................................................................................

............................................................................................................................................................................................................................................

List regular medications and doses : ..........................................................................................................................................................

**Privacy Patient Information**

This information is usually collected from the patient but also from family members and other health care provider’s.

At times some of this information needs to be shared with other health care providers or we may be legally bound to disclose personal information. All persons accessing your health information are bound by confidentiality. Please ask your Doctor if you have any concerns, questions or complaints about any issues related to the privacy of your personal information.

**Consent: The practice sends reminders by post for vaccine, Pap test and other health reviews. I consent to the practice to register for PCEHR and to upload shared health summary.**

**I consent the practice to send me reminder letters when is needed according to clinical management guidelines.**

**Signature of patient or guardian Date**

Transfer of Health Information: You may have previously consulted with a GP at another practice. The health information held by

that GP may assist us with your future health needs. You may wish to have a copy or summary of your health records transferred to this practice. Please ask the receptionist for information about how this can take place.