Cairns GP MEDICAL CENTRE

Patient Information Form

Welcome to Cairns GP Medical Centre. We are commited to providing you with the best quality comprehensive care and in order to do this it is essential that your record is accurate and kept up to date.

Title	**Miss** O **Mrs** O **Ms** O **Mr** O **Dr** O **Other :**
Surname	
First Name	**Middle Initial:**
Preferred Name	**Sex**
Date of Birth	**Child Under 16** O
Marital Status	**Single** O **Married** O **Widowed** O **Defacto** **O Other**
Residential Address:	
Mailing Address:	
Phone	**Mobile** **Home**
Occupation:	**Work Phone**
Email	

Medicare Number	**Ref No:** **Expiry Date:**
DVA Number	**Expiry Date:** **Gold** O **White** O
Concession Card	**Expiry Date:** **Pension** O **Healthcare** O **DVA** O

Next of Kin:	
Phone Number:	**Relationship:**
Emergency Contact (Different from NOK)**:**	
Phone Number:	**Relationship:**

Country of Birth:	**Primary Language:**
If you require an interpreter please advise reception:	
Do you *identify* as: O Aboriginal O Torres Strait Islander O Both O Neither	
Cultural Needs or Religious Beliefs:	

Children Under 16 require an adult to be the Primary Account Holder as Medicare will not accept claims for children. **Relationship:**	
Please indicate who is the Legal Guardian: O Next of Kin O Emergency Contact	
Name:	**DOB:**

Reminder Systems

As an integral tool in proactively caring for our patients, our practice provides preventative care and early case detection reminders e.g. immunisations, annual health checks, skin checks and pap smears.

What is your preferred method of contact: O Mobile O email O Letter

O **Are you a visitor**	O **or are you considering becoming a regular patient?**
Previous Practice and Contact Information:	
How did you hear about our practice?	

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Your Health and Family History: Please advise us if you have or had any history of the following:

Your History: O Operations O Asthma O Diabetes O Hypertension O Chronic Illness O Other

Please give details: _____

Your Family History: O Operations O Asthma O Diabetes O Hypertension O Chronic Illness O Other

Please give details: _____

Do you have any allergies or are you sensitive to drugs or dressings? O Yes (list below) O No

_____

Current Medications (Please include over the counter medications, vitamins and minerals):

_____

Is there any other information that you believe we should know that may affect/or have an influence on the medical treatment/advice you will be provided with? If Yes, please provide details: _____

_____

Social History:

Tobacco: O I have never smoked

O Ceased Smoking: ___ / ___ / ___ or _____ per day / week

Alcohol: O I do not drink alcohol

O _____ drinks per day/week/month (please circle)

Recreational Drug Use: O _____(type and frequency)

For those 65 years and older: When was the last time you were immunised?

Influenza	**Date:**	O Not sure	O Never
Pneumococcal Pneumonia	**Date:**	O Not sure	O Never

Females: When was the last time you had?

Pap smear	**Date:**	O Not sure	O Never
Breast Check	**Date:**	O Not sure	O Never
Males: When did you last have an overall check up?	**Date:**	O Not sure	O Never

I have read and agree with the CGPMC *Privacy and Confidentiality Policy* and consent to my personal health information being used or disclosed by the practice for the following purposes:

1. **Follow up reminder/recall notices for treatment and preventive healthcare**
2. A health summary being uploaded to "My Health Record" if applicable to help other health professionals that I may see to help with the continued management of my health and wellbeing.
3. For accounting procedures and the collection of professional fees
4. The diagnosis and treatment of any health condition, including the communication of relevant information only, to practice staff, specialists and other healthcare providers to ensure quality care is provided
5. For legal related disclosure as required by a court of law
6. For the purposes of research only where de-identified information is used
7. To allow medical students and staff to participate in medical training/teaching using only de identified information
8. For disease notification as required by law.
9. For use when seeking treatment by other doctors in this practice.
10. For professional and confidential Accreditation and Quality Assurance activities required by Government and RACGP regulators necessary for maintaining the high standards of care given at this practice.

Print Name:	**DOB:**
Signature of Patient or Guardian:	**Date**