

Patient Information Form

Welcome to Cairns GP Medical Centre. We are committed 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 <input type="radio"/> Mrs <input type="radio"/> Ms <input type="radio"/> Mr <input type="radio"/> Dr <input type="radio"/> Other :	
Surname		
First Name		Middle Initial:
Preferred Name		Sex
Date of Birth		Child Under 16 <input type="radio"/>
Marital Status	Single <input type="radio"/> Married <input type="radio"/> Widowed <input type="radio"/> Defacto <input type="radio"/> Other <input type="radio"/>	
Residential Address:		
Mailing Address:		
Phone	Mobile	Home
Occupation:	Work Phone	
Email		

Medicare Number	Ref No:	Expiry Date:
DVA Number	Expiry Date:	Gold <input type="radio"/> White <input type="radio"/>
Concession Card	Expiry Date:	Pension <input type="radio"/> Healthcare <input type="radio"/> DVA <input type="radio"/>

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 <i>identify</i> as: <input type="radio"/> Aboriginal <input type="radio"/> Torres Strait Islander <input type="radio"/> Both <input type="radio"/> 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: <input type="radio"/> Next of Kin <input type="radio"/> 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: <input type="radio"/> Mobile <input type="radio"/> email <input type="radio"/> Letter

<input type="radio"/> Are you a visitor <input type="radio"/> or are you considering becoming a regular patient?
Previous Practice and Contact Information:
How did you hear about our practice?

Patient Information Form

Your Health and Family History: Please advise us if you have or had any history of the following:	
Your History: <input type="checkbox"/> Operations <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Hypertension <input type="checkbox"/> Chronic Illness <input type="checkbox"/> Other Please give details: _____	
Your Family History: <input type="checkbox"/> Operations <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Hypertension <input type="checkbox"/> Chronic Illness <input type="checkbox"/> Other Please give details: _____	
Do you have any allergies or are you sensitive to drugs or dressings? <input type="checkbox"/> Yes (list below) <input type="checkbox"/> 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: <input type="checkbox"/> I have never smoked <input type="checkbox"/> Ceased Smoking: ___ / ___ / ___ or _____ per day / week Alcohol: <input type="checkbox"/> I do not drink alcohol <input type="checkbox"/> _____ drinks per day/week/month (please circle) Recreational Drug Use: <input type="checkbox"/> _____ (type and frequency)

For those 65 years and older: When was the last time you were immunised?			
Influenza	Date:	<input type="checkbox"/> Not sure	<input type="checkbox"/> Never
Pneumococcal Pneumonia	Date:	<input type="checkbox"/> Not sure	<input type="checkbox"/> Never

Females: When was the last time you had?			
Pap smear	Date:	<input type="checkbox"/> Not sure	<input type="checkbox"/> Never
Breast Check	Date:	<input type="checkbox"/> Not sure	<input type="checkbox"/> Never
Males: When did you last have an overall check up?		<input type="checkbox"/> Not sure	<input type="checkbox"/> Never

I have read and agree with the CGPMC <i>Privacy and Confidentiality Policy</i> and consent to my personal health information being used or disclosed by the practice for the following purposes:	
<ol style="list-style-type: none"> 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