NEW PATIENT INFORMATION FORM

We are committed to providing our patients with the best care.
To do this, it is essential that your personal information is up to date and accurate.

Curtis Medical

18 Gehrke Rd, Plainland, Q 4341
P: 07 5465 7522 F: 07 5465 7533

Curtis Medical has a zero-tolerance policy towards abuse against our staff
Offenders will be banned from the practice.

* FIRST NAME	*PREFERRED NAME	* MISS * MS *MRS *MR *DR *MAST
* SURNAME		
*DATE OF BIRTH	GENDER IDENTITY Male Female Other	PREFERRED Pronoun He She Them
* MEDICARE NUMBER	Ref no:	Expiry Date:
* DVA Gold / White (Please Circle) DVA Number:		Expiry Date:
* CONCESSION CARD: Pension / HCC / Seniors card (Please circle) CONCESSION CARD NUMBER:		Expiry Date:
* Private Health Cover		
* RESIDENTIAL ADDRESS		
* POSTAL ADDRESS		
* HOME PHONE	* WORK PHONE	* MOBILE
* EMAIL		
* MARITAL STATUS		
* OCCUPATION		
* COUNTRY OF ORIGIN		

DETAILS OF YOUR NEXT OF KIN	DETAILS OF YOUR EMERGENCY CONTACT
* NAME:	* NAME:
* RELATIONSHIP TO PATIENT:	* RELATIONSHIP TO PATIENT:
* ADDRESS:	* ADDRESS:
* PHONE NUMBER: (H) (M)	* PHONE NUMBER: (H) (M)

Please Turn

Do you identify as from a culturally diverse and/or non-English speaking background?

☐ No
☐ Yes

If yes, please indicate

☐ Aboriginal or Torres Strait Islander
☐ Other Cultural Background _____

Your Health History — Do you or your parents have a history of?

☐ Operations _____
☐ Diabetes_____
☐ Hypertension _____
☐ Chronic Illness _____ ☐
Other _____

Do you have any allergies or are sensitive to drugs or dressings?

☐ Yes _____ ☐
No

Immunisations — Have you had any of the following?

Tetanus Booster	☐ Yes	☐ No
Hepatitis B	☐ Yes	☐ No
Hepatitis A	☐ Yes	☐ No
Influenza	☐ Yes	☐ No
Pneumococcal	☐ Yes	☐ No
Polio	☐ Yes	☐ No

Children's Immunisations — If completing this form for a child are their immunisations up to date:

☐ Yes ☐ No

Current Medications:

_____

_____

_____

Females: When did you last have?

Pap Smear: Date: _____ ☐ Not Sure ☐ Never Breast
Check: Date: _____ ☐ Not Sure ☐ Never
Skin Check: Date: _____ ☐ Not Sure ☐ Never

Reminder Systems:

Our practice provides for the benefit of our patients a preventative care and early case detection reminder for e.g.: immunisations, annual health checks, skin checks and pap smears. Please ask your Doctor for further Health Information if you require or enquire at reception should you need any further information.

Other Information:

_____

Payment of Accounts:

Please note, our practice utilises TYRO for claiming and payments of services. Unless arranged prior to your appointment, this requires the full consult fee (including any non-reimbursable gap payment), to be paid on the day. All Pension Card, DVA Card holders and children under 17 years will be Bulk Billed.

I_____ (self/ parent/ guardian), have read and accept the terms of the above

Signed_____ Date _____

Results of Pathology and radiology Tests

It is the policy of the practice to only provide results to yourself or any relevant practitioners involved in your treatment for specific reasons (e.g. referred Specialists, Allied Health, compensation providers etc.) if you wish to authorise any other representative on your behalf, please note this below:

Name: _____ Relationship to You: _____

Signed: _____ Print Name: _____Date:_____

Should these details change at any time, please notify the practice as soon as possible. Please, also, be aware that we offer a recall service for some pathology, it is still the responsibility of the patient to contact us regarding obtaining results.

Privacy and Security of Health Records

On occasions details regarding your health may be shared with the relevant third parties pertinent to your healthcare needs; all necessary measures will be met to ensure your privacy and confidentiality. The National Privacy Principles in the Privacy Act sets out how this practice should collect, use, keep secure and disclose personal information. A copy of our Privacy Policy is available for all patients which outline the terms in which your health information is managed and utilised.

I consent to the collection and use of my information by this practice:

Signed: _____ Print Name:_____

Date:_____