

**GOLD COAST VASECTOMY CLINIC**  
**NEW PATIENT FORM.....Welcome to our practice**

*Please complete this form and bring to reception 10 minutes before your initial consultation*

We need this information to provide you with the best quality of care. Our practice follows the guidelines of The Royal Australian College of General Practitioners Handbook for the management of health information in private medical practice. This means your personal health information is kept private and secure, as required by federal and state privacy laws.

**PATIENT DETAILS**

Surname \_\_\_\_\_ Given Names \_\_\_\_\_ Title \_\_\_\_\_  
Date of birth \_\_\_/\_\_\_/\_\_\_ Occupation \_\_\_\_\_  
Marital status    Single            Married            Defacto            Separated            Divorced            Widowed  
Are you of Aboriginal or Torres Strait Islander origin            Yes            No  
Home address \_\_\_\_\_  
Postal address \_\_\_\_\_  
Phone (home) \_\_\_\_\_ (work) \_\_\_\_\_ (mobile) \_\_\_\_\_  
Name of normal GP and/or Medical Practice \_\_\_\_\_

Medicare Card Number \_\_\_\_\_ / \_\_\_\_\_            Expiry date \_\_\_\_\_  
Veterans' Affairs Card Number \_\_\_\_\_            Expiry date \_\_\_\_\_  
Health Care Card Number \_\_\_\_\_            Expiry date \_\_\_\_\_  
Pension Card Number \_\_\_\_\_            Expiry date \_\_\_\_\_

**EMERGENCY CONTACT (next of kin)**

Name \_\_\_\_\_ Relationship to you \_\_\_\_\_  
Phone (home) \_\_\_\_\_ (work) \_\_\_\_\_ (mobile) \_\_\_\_\_

How did you hear about our practice?

Family                      Internet                      GP \_\_\_\_\_  
Friends                      Yellow pages                      Other (please specify) \_\_\_\_\_

**Cancellation Policy**

We ask that if you cannot make your scheduled appointment you contact us as early as possible. This will ensure other people do not miss out on available appointments. Failure to give us notice may incur a late cancellation fee.

*Please turn over...*

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**Privacy Patient Information**

To provide a high standard of medical care our practice undertakes research, professional development, and quality assurance/improvement activities. Any person accessing personal health information for this purpose has signed a written confidentiality agreement.

I consent to my health record being reviewed as part of the quality improvement activities at this practice  
Yes                      No

At times some of your medical information may need to be shared with other health care providers. Our practice uses encrypted e-mail as a form of communication with other health professionals, for example, specialists.

I consent to my medical information being transmitted via e-mail                      Yes                      No

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**HEIGHT (cm)** \_\_\_\_\_ **WEIGHT (kg)** \_\_\_\_\_

**ALLERGIES, INTOLERANCES & SENSITIVITES**

1.	3.
2.	4.

**HISTORY OF MEDICAL PROBLEMS (including year of onset or diagnosis)**

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

**HISTORY OF OPERATIONS (including year)**

1.	4.
2.	5.
3.	6.

**FAMILY HISTORY**

1.	3.
2.	4.

**CURRENT MEDICATIONS & DOSAGE (including over the counter medications)**

1.	5.
2.	6.
3.	7.
4.	8.

Smoking status?      Current      Ex      Never      Number of cigarettes per day \_\_\_\_\_

Alcohol – how many alcoholic drinks do you have each week \_\_\_\_\_  
 (one standard drink = 425ml light beer/285ml full strength beer/100ml wine/30ml spirits/60ml port or sherry)

Signature of patient \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

*Thank you for completing our New Patient Form....*