GOLD COAST VASECTOMY

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. If you wish to review our full privacy policy please request a copy from one of our reception staff.

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 If Yes, please advise _____________

Home address____

Postal address____

Phone *(home)*___________________ *(work)* __________________ *(mobile)* _____________________

E-mail ____

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…

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 am aware there may be a small risk in transmitting information, however, I consent to my medical information being transmitted via encrypted electronic communication or fax (**N.B.** if you answer No to this question then you are required to take paper copies of all documents, including referrals to other healthcare providers, insurance companies, etc) ☐Yes ☐No

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SURNAME______________________________ **GIVEN NAME**______________________________

HEIGHT (cm)____________________________ **WEIGHT (kg)**________________________________

ALLERGIES, INTOLERANCES & SENSITIVITES (specify type of reaction e.g. rash)	
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 Year started _______Year stopped ________
Number of cigarettes per day __________

Alcohol How many days a week do you drink alcohol? __________
On days when drinking, number of standard drinks consumed? __________
(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….