New Patient Information Form

This form complies with the *RACGP 5th Edition Standards for General Practice*. This means your personal health information is kept private and secure. Please complete this form accurately and fully:

Title:		**Date of Birth:**	
Full Name (incl. Middle):			
Street Address:	**Suburb & Postcode:**		
Postal Address:			

Birth Sex:	Male Female Other	**Gender Identity:**	**Pronouns:**

Home Phone:		**Mobile:**	
Email:			
SMS Consent:	☐ Appointments ☐ Clinical Communication ☐ Clinical Reminders ☐ Health Awareness		

NEXT OF KIN

Name:		Relationship to you:
Contact:		Alternate Contact:

EMERGENCY CONTACT

Name:		Relationship to you:
Contact:		Alternate Contact:

HEALTHCARE IDENTIFIERS

Medicare Number: __ __ __ __ __ __ __ __ __ __ Ref (next to name): _____ Expiry: _____/_____

Dept. of Veterans' Affairs File Number: _____ ☐ Gold ☐ White

Concession Number: _____ ☐ Pension ☐ HealthCare Expiry: ___/___/_____

CULTURAL IDENTITY

To assist with health initiatives - are you Aboriginal and/or Torres Strait Islander?

☐ No ☐ Yes – Aboriginal ☐ Yes - Torres Strait Islander ☐ Yes - Aboriginal and Torres Strait Islander

Country of Birth: _____ *Do you require an interpreter service?* ☐ No ☐ Yes

SOCIAL HISTORY

Marital Status:	Single Married Defacto Separated Divorced Widowed
Accommodation:	Own Home Rental Home Other House Hostel Nursing Home Homeless
Do you feel safe in your home?	YES or NO
Occupation:	
Carer:	Do you have a Carer? YES NO *If yes, provide Carer details:*

Patients are reminded that we have a Zero Tolerance Policy on issues relating to violence and aggression. Any such issues may result in the transfer of your care. Please be aware that our GPs at this practice, will not prescribe 'Drugs of Addiction' unless clinically indicated by the treating GP. It is our practice Policy not to prescribe these drugs until the full clinical picture has been obtained.

v1.0 01.08.2026

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YOUR HEALTH HISTORY:

Current Weight: _____kg **Current Height:** _____cm

Do you Smoke:	YES NO	If yes, how many per day:
Do you drink Alcohol:	YES NO	If yes, how many standard drinks per day/week:
Allergies:	YES NO	If yes, reaction to:_____ **Symptoms:** **Severity:** MILD MODERATE SEVERE
Blood Group:	**Group:** A B AB O	**Rh:** Positive *or* Negative
Current Medications:		
Diagnosed Illness(s) or Operation(s):		

FAMILY HISTORY:

Mother Alive? YES NO	**Age of Death:**	**Cause of death:**
Father Alive? YES NO	**Age of Death:**	**Cause of death:**

SIGNIFICANT FAMILY HISTORY:

Mother: ☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke ☐ Cancer of _____ ☐ Depression

Father: ☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke ☐ Cancer of _____ ☐ Depression

Other Family: (Any significant family members with medical conditions):

BILLING INFORMATION

THIS IS A BULK BILLING PRACTICE FOR ALL ELIGIBLE GP CONSULTATIONS.

A valid Medicare Card must be provided to be eligible for Bulk Billing.

Note: Private Fees apply for all other consultations and treatment room procedures not eligible for Bulk Billing.

Check with reception if your consultation will be bulk billed. **Late cancellations and missed appointments will result in a *"did not attend"* fee being applied. Administration fees will also be added to any outstanding invoices.**

PATIENT CONSENT:

By becoming a patient of Bertram GP & Skin Clinic and signing this New Patient Information Form I agree and consent to the following:

- I consent to the use of my personal health information by Bertram GP & Skin Clinic and other health care providers involved in my medical treatment and health care within this centre.
- I consent to the disclosure of my personal health information by the above-named practice to other health care providers involved directly or indirectly involved in my personal health care or medical treatment.
- As part of quality improvement, we share de-identified data. I consent to the sharing of de-identified data in order to assist with quality improvement.
- As part of preventative health services offered by this practice, we send out follow up reminders and recalls when routine investigations are due.
- I consent to receive follow up reminders and recalls to be sent through my preferred method of contact.
- Our practice may participate in clinical research and may contact you for participation in a clinical trial should you meet criteria. Your participation is optional. Please let us know if you do not consent to the above clinical research participation option. This will not affect the care you receive.

I have read the information above and give my consent to my personal information being collected and used as stated above:

Patient or Guardian name: (please print) _____

Signature: _____ Date: _____

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