APOLLO GENERAL PRACTICE
ABN: 25 569 812 490
Clinic: 75 Bowman Road, Caloundra
Postal: PO Box 1495, Caloundra QLD 4551
Phone: 07 5438 1200
Fax: 07 5438 1300
www.apollogp.com.au

NEW PATIENT REGISTRATION FORM

Title: _____ **Family Name:** _____

Given Name: _____ **Middle Name:** _____

Preferred Name: _____ **Date of Birth:**_____

Sex: (Please Circle) **Female** **Male**

Ethnicity: **Aboriginal** **Torres Strait Islander** **Australian/Non-Indigenous** **Other**:_____
(Please Circle)

Are you registered for the CTG PBS co-payment? **Yes** **No**

Occupation:_____

CONTACT DETAILS:

Residential Address: _____

_____

Postal Address: _____

Home Phone :_____ Work Phone:_____

Mobile: _____

Email:_____

Medicare Number: __ __ __ __ __ __ __ __ __ __ **Reference Number:** __ (left of your name) **Exp:** ____/____

Pension Card / Healthcare Card _____**Expiry date:** _____/_____/_____

DVA : _____ **TYPE:** _____

NEXT OF KIN/ EMERGENCY CONTACT:

Name:_____ **Contact Number:** _____ **Relationship to you:**_____

Name:_____ **Contact Number:** _____ **Relationship to you:**_____

CONSENT:

To provide you with a quality health service we may disclose selected personal health information to others involved in your treatment and care, such as: a treating hospital, specialist, pathology provider and x-ray departments. We only disclose those details necessary for you to receive appropriate care from the health service concerned. Limited information must be disclosed by law to Government bodies for billing services e.g.: Medicare.

By signing below, you also consent to be contacted by the practice via mail, phone, email or SMS for Recalls and Reminders.

Patient / Guardian Name: _____ **Date:** ____/_____/____

Signature: _____

Please Turn Over

Please complete this form fully, as it will assist us with the management and continuity of your health care.

CURRENT HISTORY:

ALLERGIES: _____

_____

MEDICATIONS: (List all medications you are taking NOW) _____

_____

_____

SIGNIFICANT FAMILY HISTORY: (Please Circle)

Nil Known **No Significant history**

MOTHER: (Please Circle) **Diabetes** **Colon Cancer** **Hypertension** **Depression**

Heart Disease **Breast Cancer** **Stroke**

FATHER : (Please Circle) **Diabetes** **Colon Cancer** **Hypertension** **Depression**

Heart Disease **Stroke**

MARITAL STATUS: (Please Circle) **Married** **Single** **de facto** **Separated** **Divorced** **Widowed**

ACCOMMODATION: (Please Circle) **Own Home / Renting / Nursing Home / Hostel / Homeless / Relative**

Who do you live with? _____

Do you have a Carer? _____

ALCOHOL: (Please Circle) **Non Drinker** **Drinker**

Days per week: _____ **Standard drinks per day:** _____

SMOKING: (Please Circle) **Smoker** **Non Smoker** **Ex-Smoker** **Date ceased:** _____

How many per Day? _____

ARE YOU... (Please Circle) **On holiday** **Visiting relatives** **Relocated to the Sunshine Coast**

How did you hear about APOLLO GENERAL PRACTICE? (Please Circle)

Yellow Pages/White Pages **Local Search** **Facebook** **Newspaper Ad**

Welcome Postcard **Accommodation** **Google Search**