



www.apollogp.com.au

# 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



## 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

Full Name: \_\_\_\_\_ Contact Number: \_\_\_\_\_ Relationship to you: \_\_\_\_\_

### EMERGENCY CONTACT

Full Name: \_\_\_\_\_ Contact Number: \_\_\_\_\_ Relationship to you: \_\_\_\_\_

### CONSENT:

By becoming a patient of Apollo General Practice and signing this new patient form I agree and consent to the following:

\* Disclosure of selected personal health information to others involved in your treatment and care, such as: a treating hospital, specialist, pathology and imaging providers. 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.

\* 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.**

**PATIENT HISTORY:**

**OPERATIONS / ILLNESSES:** \_\_\_\_\_

\_\_\_\_\_

**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