Apollo
GENERAL PRACTICE

ABN: 25 569 812 490
75 Bowman Road, Caloundra
PO Box 1495, Caloundra QLD 4551
P: 07 5438 1200
F: 07 5438 1300

NEW PATIENT REGISTRATION FORM

Title: ________________________ **Family Name:** ________________________________

Given Name: ____________________________ **Middle Name:** ____________________________

Preferred Name: __________________________ **Date of Birth:**__________________________

Birth Sex: **Female** **Male**

Gender Identity: **Female** **Male** **Non-Binary** **Gender diverse** **Transgender** **Different identity** __________

Ethnicity: **Aboriginal** **Torres Strait Islander** **Australian/Non-Indigenous** **Other**:__________________

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 below, I agree and consent to:
* Disclosure of selected personal health information to others involved in my treatment and care, such as: a treating hospital, specialist, pathology and imaging providers. The practice will only disclose those details necessary for me 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.
* Contact by the practice via mail, phone, email or SMS for Recalls and Reminders.
* the Practice's Billing Policy.

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**