# New Patient Form

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Chinchilla QLD 4413
Phone: 07 4662 7188
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**This information is private and confidential and is for use in your clinical file only**
**Doctors at this practice use Pen CS Software to help provide you with the best medical care.**

| **Personal Details:** | | | | | |
|---|---|---|---|---|---|
| **Title:** | | **Surname:** | | **First Name:** | |
| **Middle Name:** | | **Preferred Name** | | **Date of Birth:** | / / |
| **Birth Sex:** | Male / Female (please circle) | **Gender Identity:** | Male / Female / Transgender / Different Identity | | |
| **Residential Address:** | | | | | |
| **Postal Address:** | | | | | |
| **Home Phone:** | | **Mobile Phone:** | | **Work Phone:** | |
| **Email:** | | **Occupation:** | | | |
| **Consent to upload My Health?** | ☐ **Yes** | ☐ **No** | | | |

| **Health Care Details:** | | | |
|---|---|---|---|
| **Medicare Number** | | **IRN (next to name):** | **Expiry:** |
| **DVA Gold / White** (Please Circle) | | **Expiry Date:** | |
| **Pensioner Concession Card** | | **Expiry Date:** | |
| **Health Care Card** | | **Expiry Date:** | |
| **Private Health Insurance Fund Name** | | **Fund Number:** | |

| **Emergency Contact Details:** | | |
|---|---|---|
| **Next of Kin (Name):** | **Contact Number:** | **Relationship:** |
| **Emergency (Name):** | **Contact Number:** | **Relationship:** |

**Australia is a genuinely multicultural society. To tailor appropriate care, encourage understanding and appreciation between people from different nationalities and backgrounds please complete this section**

| | |
|---|---|
| **Country of Birth:** | |
| **Do you require a Translator?** Yes ☐ No ☐ | **Ethnicity:** |
| **To assist with health initiatives – are you Aboriginal or Torres Strait Islander?** (please tick)<br>Aboriginal   Torres Strait Islander   Aboriginal & Torres Strait Islander   No | |

## Transfer of Medical Records:

In order to provide you with the best possible care, I agree to the Chinchilla Medical Practice obtaining my records from my previous doctor. Transfer via Medical Objects is our preferred method.

Signature__________________________________________________ Date______/_______/_______

Previous Practice: __________________________ Phone: ____________________ Fax: ____________________

**Please send Medical Records via Medical Objects to Dr ______________________**