New Patient Information Form

Payment for your consultation must be made directly after your consultation.

Queen Street Medical Centre

New Patient Information			
Date of Birth		**Title** (ie Miss, Mrs, Ms, Mr, Dr)	
First Name		**Surname/Last Name**	
Preferred Name		**Birth Sex**	□ Male □ Female
Gender Identity	□ Male □ Female □ Non-binary □ Transgender MTF / FTM □ Other:		
Ethnicity	□ Australian, non-indigenous	□ Aboriginal	□ Torres Strait Islander
	□ Aboriginal & Torres Strait Islander	□ Other nationality:	
Australian Residential Address			
Postal Address (if different to above)			
Contact Phone	**Mobile:**	**Work:**	**Home:**
Email			
Preferred contact	□ SMS □ Phone call (Mobile) □ Phone call (Home) □ Email □ Letter (Post)		
Medicare No.		Ref:	Expiry:
Allianz OSHC Insurance Policy No. (if applicable)			Expiry:

Emergency Contact Person ☐ Same as Next of Kin		**Next of Kin**	
Name		Name	
Relationship		Relationship	
Phone No.		Phone No.	

Are you temporarily visiting or travelling in Brisbane? □ YES □ NO		
Allergies	Do you have any known allergies (medicine, food, environment)? □ No known allergies □ YES (discuss with GP)	
Marital status	□ Single □ Married □ Defacto □ Separated □ Divorced □ Widowed	
Sexual orientation	□ Heterosexual □ Homosexual □ Bisexual	
Lives with	□ Spouse □ Friend □ Relative □ Alone □ Carer	
Occupation		
Alcohol Intake	How many days per week do you drink alcohol?	
	How many alcoholic drinks would you have on these days?	
Smoking Status	□ Non-smoker □ Smoker □ Ex-smoker □ E-cigarette (Vaping)	

I consent to the following (please tick accordingly):

☐ *I agree to my emergency contact and/or next of kin being contacted in the case of an emergency or if we are unable to contact you for healthcare reasons.*

☐ *I agree to receive SMS messages and/or emails for appointment confirmations, results follow up notifications and preventative health reminders.*

☐ *I understand that the doctors at this practice will not prescribe Schedule 8 Drugs, antipsychotics, benzodiazepines, or opioids to new patients.*

☐ *I agree to the GP and/or Nurse at Queen St Medical Centre accessing and uploading information to My Health Record for the provision of healthcare in accordance with national legislation.*

☐ *I understand Queen Street Medical Centre is a private billing practice and payment must be made directly after the consultation.*

Signed: _____ **Date:** _____