Googong Family Practice - New Patient Demographic Information Form

Please complete or circle appropriate options

Title	Mr Mrs Ms Miss Mast Other _____				
Family Name		**Given Name**			
Middle Name		**Preferred Name**			
Date of Birth		**Birth Sex**	Male Female Other Unknown		
Gender Identity	Male Female Non-Binary Gender diverse Transgender Different identity	**Preferred Pronoun**	She / Her / Hers He / Him / His They / Them / Theirs		
Ethnicity	Australian non-indigenous Aboriginal (but not Torres Strait Islander) Torres Strait Islander (but not Aboriginal) Both Aboriginal and Torres Strait Islander Other (please specify ethnicity or country) _____ Do not wish to provide				
Home Address Line 1		**Home Address Line 2**			
City / Suburb		**Postcode**		**State**	
Postal Address					
Home Phone		**Work Phone**		**Mobile Phone**	
Email					

Your Privacy & Communication Consent

On occasions, we may need to contact you to inform you of results, public health issues, health prevention activities eg flu vaccinations and reminders. To do this, we may use phone, email, sms, our practice App or direct mail.

If you **DO NOT** wish for one or more of the above communication methods to be used, please identify which means of communication we **MAY NOT** use: _____

Sentinel Practices Data Sourcing Project (SPDS)

This practice participates in the SPDS Project. This involves sharing **DE-IDENTIFIED** data to the South Eastern NSW Primary Care Network (Coordinare – www.coordinare.org.au) for the purposes of:

- Identifying information on disease prevalence, risk factors and patient presentations
- Using the above information, planning tailored population health programs and quality improvement aimed at improving the health and clinical outcomes of our patients and the surrounding population accessing primary care services
-

If you **DO NOT** wish your **DE-IDENTIFIED** data to be used, please place a X in this box: ☐

For our full privacy statement please go to our website at www.googongfp.com.au.

Return to: admin@googongfp.com.au

Please continue overleaf

Medicare No.		**Line No.**		**Expiry Date**	
Pension / HCC No.		**Card Type**	Pension HCC	**Expiry Date**	
DVA No.		**Card Colour**	Gold White Orange	**Conditions Covered**	
Health Fund		**Expiry**		**Fund No**	
Head of Family	Self / Other (Please specify):				
Next of Kin		**Relation-ship**		**Phone**	
Address					
Emergency Contact		**Relation-ship**		**Phone**	
Authorised persons	I authorise the following persons to act on my behalf in regards to my medical and personal information. This may include but is not limited to: requesting results, discussing my health				
Authorised person	My Next of Kin: YES NO				
Authorised person	My Emergency Contact YES NO				
Authorised person		**Relation-ship**		**Phone**	
Current Occupation					
Previous Occupations					

Guardianship / Parenting Orders

If there are any court or voluntary orders in place for the above patient, please complete the following:

Name of Guardian / Parent		**Phone**	
Type of order	Guardianship Order Parenting Order		
Purpose of order			
Please provide a copy of the order for our records			

I, _____ , confirm the above information is true and correct.

Return to: admin@googongfp.com.au

Signature Patient / Parent / Guardian _____ Date: _____

(Please circle)

Return to: admin@googongfp.com.au