New Patient Information

Cairns Diabetes & Endocrinology

Title:	*First Name:*	*Surname:*
Preferred Name:	*DOB:*	
Residential Address:		
Postal Address:		
Email Address:		*Occupation:*
Ph Home:	*Ph Work:*	*Ph Mob:*
What is your preferred method of contact: (tick as many as applicable) ☐ Mobile ☐ Home Phone ☐ Email ☐ Next of Kin		
Medicare Care Number:	*Reference No: (digit in front of name)*	*Expiry:*
Health Fund Name:	*Health Fund Card Number:*	

Do you hold any of the following concessions:

☐ DVA Gold	☐ DVA White	☐ ADF Membership	☐ Third Party Insurance
Card/Policy Number:		Expiry:	

Do you identify as:

☐ Aboriginal	☐ Torres Strait Islander	☐ Both	☐ Neither

Social history:

Tobacco use	☐ Non Smoker	☐ Current smoker _____ per: Day / Week	☐ Ceased smoking: _____
Alcohol intake	☐ Non Drinker	_____ units per: Day / Week / Month *(please circle)*	

Referral information:

Referring Doctor:	Clinic:
General Practitioner:	Clinic:

Next of Kin:

Name:	
Relationship:	Phone Number:

Emergency Contact: (if different from above)

Name:	
Relationship:	Phone Number:

Please Turn Over

Consent to release medical information:

- ☐ I give my consent to **Cairns Diabetes & Endocrinology**, or their agents or advisors, to contact medical practitioners or other bodies I have consulted to obtain health and other information that may be pertinent to my care.
- ☐ Information can be transferred to and from medical practitioners and other bodies by channels such as email, fax and secure message systems.
- ☐ I authorise those medical practitioners or bodies to release such information, which may include sensitive information to **Cairns Diabetes & Endocrinology**, or their agents and advisors, as may be required.

Patient Details:

Patient name:	
Date of Birth:	
Signature:	
Date:	

Parent/ Guardian Details:

Parent/Guardian name:	
Signature:	
Date:	