New Patient Registration Form

The Doctors and Staff at this clinic are committed to whole patient care. This includes preventive care as well as ongoing care. To enable us to carry this out, please complete the following form. This information will be treated confidentially. Thank you for your assistance. Please return this form to the receptionist once you have finished completing it, together with your Medicare card and any concession cards.

Personal details

Title.....First Name.....
Surname.....
Date of Birth...../...../.....
Gender Male ❑ Female ❑ Other ❑
Address.....
.....

Email address…….

Home Phone.....Mobile Phone.....

Do you consent to be contacted by email and/or SMS:
Email: Yes ❑ No ❑ SMS: Yes ❑ No ❑

Occupation.....

Medicare number:…… Number on card: ……. Expiry: ….....
Pension/DVA number:…….. Number on card: ……. Expiry:……

Ethnic Background

Are you Aboriginal or Torres Strait Islander? (If Yes, you may be entitled to increased Medicare benefits)

No ❑ Torres Strait Islander ❑ Aboriginal ❑

Your cultural background may increase your risk of certain illnesses. To help us provide you with the highest standard of care, please let the practice know your cultural background and /or language.

Cultural background .....
Country of birth.....
Language.....

Next of Kin

Name: ……. Phone: ……
Relationship: ……..

Emergency Contact

Who should we contact in an emergency situation?
Name .....
Relationship .....
Phone .....Mobile.....

Marital status

Married ❑ De-facto ❑ Single ❑ Widowed ❑ Divorced ❑ Separated ❑

Private Health Insurance

No ❑ Yes ❑: Hospital ❑ Extras ❑

Are you planning to remain a patient of our practice for at least the next 12 months?
Yes ❑ No ❑

How did you hear about our practice? ……

Reminder System

This practice takes a preventive approach to your health. You may receive reminder letters or be reminded at your next visit of ongoing follow-up for preventive care. If you do not want to part of this system, please inform the receptionist. This correspondence may be via email or SMS text message.

Privacy

We must obtain your consent for messages to be left on your telephone answering machine or with whoever answers your phone regarding matters involving your health. We may also send SMS appointment reminders or email Reminders. Please sign below to give your consent for this to occur.

Signature .....Date.....

Please provide a photocopy of your current Drivers Licence or other form of photo identification.

Medical History Form (OPTIONAL)

This information will be treated confidentially and you do not have to answer any or all questions if you'd rather discuss them in person with the doctor. The information provided will help make your consultation more efficient. Please return this form in person to the doctor at the beginning of your consultation.

Full name.....

Past Medical History

.....
.....
.....

Family Medical History

.....
.....

Past Surgical History (e.g. Operations, Fractures etc)

.....
.....
.....

Medications

.....
.....
.....
.....
.....

Women's Health (if applicable)

When was your last Cervical Screening Test (papsmear)?.....
When was your last mammogram?.....
How many pregnancies have you had?.....

Mental Health History

.....
.....
.....

Other

Do you smoke? ❑ yes ..... cigs/day
❑ no
❑ ex-smoker

Do you drink alcohol? ❑ yes How often?.....
How many per session?.....
❑ no

Do you take or have you taken any other street drugs now or in the past? ❑ yes ❑ no

Do you have any allergies?
❑ yes .....
❑ no

This information will be shredded once the doctor has entered necessary information into your confidential patient record.