NEW PATIENT REGISTRATION

We are committed to providing our patients with the best care. To do this it is essential that your health record is kept up to date and accurate. Could you please assist us by completing the following:

Title ◯ Mr. ◯ Dr. ◯ Mrs. ◯ Ms. ◯ Miss ◯ Master ◯ Other _____

Surname _____ First Name _____ Preferred Name _____

Date of Birth _____ Birth Sex _____ Gender Identity _____

Country of Birth ◯ Australia ◯ Other _____ Language spoken at home _____

Cultural background: For more info on why this is important, please visit www.aihw.gov.au or www.abs.gov.au

◯ Aboriginal ◯ Torres Strait Islander ◯ Cultural Background (eg. Greek, Chinese) _____

Address: _____ Suburb: _____ Post Code: _____

Mobile Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____ Medicare No: _____ Ref No: ____ Expiry _____

◯ Pension Card or ◯ Health Care Card _____ Expiry _____

DVA Gold/White No: _____ Expiry _____ Private Health Provider _____

Head of Family (if not self, required for patients under 18) _____

Next of Kin Name _____ Phone _____

Relationship to patient _____

Emergency Contact Name _____ Phone _____

Relationship to patient _____

Marital Status: _____ Occupation: _____

Allergies: Reaction:

_____ _____

_____ _____

Family History: ◯ Diabetes ◯ Hypertension ◯ Heart Disease ◯ Stroke

◯ Colon Cancer ◯ Depression ◯ Breast Cancer

◯ Other (please specify): _____

Dietary Patterns: _____

Recreational/Exercise Activities: _____

Accommodation: _____ Lives with: ◯ Alone ◯ Other: _____

Are you a carer for another or cared for yourself? _____

Alcohol: ◯ Yes ◯ No Days per week you drink: _____ Drinks per day: _____

Smoking Status:

◯ Never Smoked ◯ Smoker Year started: _____ Cigarettes per day: _____

◯ Ex-Smoker Year started: _____ Year stopped: _____ Cigarettes per day: _____

Past Medical History/Operations/Chronic Conditions and Illnesses' (include approx. dates)

_____

_____

_____

Are you taking any medications? If so, please list them all, including those bought over the counter, vitamins, naturopathic or homeopathic medications and occasional medications:

_____

_____

_____

Recent Immunisations:

_____

All Patients aged above 50yo: Have you had a bowel cancer screening test? ◯ Yes ◯ No

When and what was the result? _____

FEMALE Patients: When was your last cervical screening test? _____

Was the result normal? ◯ Yes ◯ No Have you ever had an abnormal result? ◯ Yes ◯ No

If aged >50, when was your last mammogram and what was the result? _____

Reminders & Communication Consent

I give consent for my Patient Health Information to be provided to Health Organisations such as The Cervical Screening Registry and Immunisation Registry. This clinic also uses SMS and Email for communication. I hereby consent to the following communications:

◯ Appointment Reminders

◯ Clinical Reminders (eg. Immunisations & Care Plans)

◯ Clinical Communications (eg. Tests normal; Cholesterol / X-ray normal but see me in two weeks)

◯ Health Awareness (eg. New doctors, Fee changes)

If my mobile number, as listed by the practice is utilized for more than one patient, I understand that all SMS communications as consented to above, will be sent to that number. Other family members aged under 18 who consent to receive communication to the same contact number:

Name: _____ DOB: _____

Name: _____ DOB: _____

Date: _____ Signature: _____