

New Patient Registration Form

Please print clearly in BLOCK LETTERS. If you need a hand with any part of this form, just ask our reception team.

1 YOUR DETAILS

TITLE

☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Mstr ☐ Dr ☐ Other

SEX

☐ Male ☐ Female ☐ Other

DATE OF BIRTH

DAY MONTH YEAR

SURNAME**FIRST NAME****MIDDLE NAME****PREFERRED NAME** what you like to be called**STREET ADDRESS****SUBURB****STATE****POSTCODE****MOBILE****HOME PHONE****WORK PHONE****EMAIL****OCCUPATION**

2 CULTURAL BACKGROUND

ARE YOU OF ABORIGINAL OR TORRES STRAIT ISLANDER ORIGIN?

☐ No ☐ Yes - Aboriginal ☐ Yes - Torres Strait Islander ☐ Yes - both

ETHNICITY / CULTURAL BACKGROUND

3 MEDICARE AND CONCESSION CARDS

MEDICARE NUMBER**REF. NO.** (next to your name)**EXPIRY** (MM / YYYY)**CONCESSION / PENSION CARD NO.****CARD TYPE****EXPIRY** (MM/YYYY)**DVA NUMBER****CARD TYPE** gold / white / orange**EXPIRY** (MM/YYYY)

4 NEXT OF KIN AND EMERGENCY CONTACT

NEXT OF KIN - NAME

RELATIONSHIP TO YOU

MOBILE

EMERGENCY CONTACT - NAME

RELATIONSHIP TO YOU

MOBILE

5 ALLERGIES AND REACTIONS

Include medicines, foods and anything else you react to. Write 'None known' if this does not apply.

ALLERGY OR INTOLERANCE	WHAT HAPPENS WHEN YOU HAVE IT

6 YOUR MEDICINES

Include prescription medicines, over-the-counter medicines, vitamins and herbal supplements.

MEDICINE NAME AND STRENGTH	DOSE AND HOW OFTEN YOU TAKE IT

7 FAMILY HISTORY

Has anyone in your family had diabetes, heart disease, stroke, cancer or another significant illness?

8 ALCOHOL AND SMOKING

Do you drink alcohol?

☐ Yes ☐ No

IF YES, ROUGHLY HOW MANY STANDARD DRINKS PER WEEK?

Do you smoke or vape?

☐ Yes ☐ No

IF YES, ROUGHLY HOW MUCH PER DAY?

9 HOW WE CAN CONTACT YOU

Tick the ways we may contact you about test results, appointment reminders and practice updates.

May we contact you by SMS?

☐ Yes ☐ No

May we contact you by telephone?

☐ Yes ☐ No

May we contact you by email?

☐ Yes ☐ No

May we send you health reminders (vaccinations, cervical screening, health checks)?

☐ Yes ☐ No

May we upload a health summary to your My Health Record?

☐ Yes ☐ No

10 PRIVACY AND CONSENT

Your privacy. Your doctor makes independent professional decisions to give you the best possible care. We take your privacy seriously and everything we hold about you is kept in strict confidence, in line with the Privacy Act.

Sharing your information. To look after you properly, other health professionals sometimes need access to your health information - for example pathology services, pharmacists, specialists, hospitals, disease monitoring agencies, your Primary Health Network and Medicare. We never sell your information, and it is never used to promote non-health products or services.

Dealing with us anonymously. You may deal with us anonymously or under a pseudonym, unless that is impractical or the law requires us to identify you. Please speak with reception if you would like to do this.

Missed appointments. Please be aware that repeatedly missing appointments without letting us know may incur a practice fee of \$44.

By signing below I confirm that:

- the information I have given on this form is correct;
- I consent to my health information being used and shared as described above;
- I consent to relevant information being shared between the GPs, specialists, nurses, nurse practitioners, allied health providers and non-clinical staff involved in my care; and
- I accept responsibility for payment of my account.

NAME (PLEASE PRINT)

RELATIONSHIP TO PATIENT if not the patient

SIGNATURE

DATE SIGNED

DAY		MONTH		YEAR	

OFFICE USE ONLY ID sighted _____ Medicare verified _____ Entered by _____ Date _____