

**New Patient Registration Form**

**Personal Details**

Title:  Mr  Mrs  Ms  Mast  Miss

First name:

Last name:

Preferred name:

Birth sex:Male FemaleGender:

Date of birth: Occupation:

Street address:

Suburb: Postcode:

Mobile phone: Home phone:

Email address:

**Health Initiatives**

In order to assist us with health initiatives and to tailor your care:

Are you Aboriginal or Torres Strait Islander:  Yes  No

What is your country of birth:

**Emergency Contact Information**

We collect this information in case of an emergency.

**Next of kin:**

First name:

Last name:

Relationship:

Contact phone number:

**Emergency contact: -** Same as Next of kin:  Yes  No

If no, please detail:

First name:

Last name:

Relationship:

Contact phone number:

**Medical Information**

Do you have a Medicare card:YesNo

If yes:

Card no: Ref: Expiry date:

Do you have a DVA card?  Yes  No

If yes:

Card no: Expiry date:

Do you have a Pension card?  Yes  No

Do you have a Health Care card?  Yes  No

If yes:

Card no: Expiry date:

**Health History**

Any allergies or sensitivity to drugs or dressings:  Yes  No

If yes: please detail:

Operations:  Yes  No

Asthma:  Yes  No

Hypertension:  Yes  No

Chronic illness  Yes  No

Other:  Yes  No

If yes, please detail:

Cervical screening?  Yes  No  Not sure  Not applicable

If yes, when?

Mammogram?  Yes  No  Not sure  Not applicable

If yes, when?

Prostate check?  Yes  No  Not sure  Not applicable

If yes, when?

**Immunisations**

Have you had the following immunisations:

Tetanus booster  Yes  No  Unsure

Hepatitis B  Yes  No  Unsure

Hepatitis A  Yes  No  Unsure

Influenza  Yes  No  Unsure

Pneumococcal  Yes  No  Unsure

Polio  Yes  No  Unsure

**Current medication (incl. over-the-counter, vitamins, minerals)**

**Family History (have any family members had)**

Diabetes  Mental illness  Asthma

Cancer  Heart disease

**Social Activities**

Do you smoke:  Yes  No  Ceased

If yes, how many per day/week:

If ceased, when?

Do you drink alcohol?  Yes  No  Ceased

If yes, how many per day/week/month?

Height: cms Weight: kgs

**Communication**

I consent to receive SMS reminders and messages: Yes  No

**Privacy and Terms**

We are committed to protecting the confidentiality of your personal information and health records. In submitting this form, you;

1. Acknowledge that we, and our service providers, will collect your personal and health information to enable us to provide you with our health services and any related communications (for example, to manage your appointment bookings); and
2. Consent to our handling of your personal information in accordance with our Privacy Policy (you can access our Privacy Policy on our website, or by asking us for a copy).

Do you agree to the terms?

I agree

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_