

**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:[ ] Yes[ ] No

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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_