Registration form for new patients

Please bring this form with you into your first appointment Today's date:………/…………/……….

Title:……………. Surname:…………………………………………… First Name:………………………….………

Middle Name:……………………………………….……….Preferred Name……………………………….…………

**Please use the same name as shown on your Medicare card/the name you use when attending pathology, radiology etc. This is to ensure your results are received correctly.*

Date of Birth:………./……………/……….. Male ☐ Female ☐

Address:……..

Suburb………………………………………………………………………………………Post Code…………………………..

Contact Phone Number: Mobile……………………..……………….……..Home:……………………..………

Email address:…………………………………………@………………………………………………………………

Occupation:…………………………………………………… Marital Status:…………………………………………

Country of Origin:…………………………………………Interpreter Services Required? Yes ☐ No☐

Do you identify yourself as Aboriginal or Torres Straight Islander? Yes ☐ No☐

Medicare Card Number: …………………………………………. Line Number ☐ Expiry………/……….

DVA Number: ………………………………………Type: Gold ☐ White ☐ Lilac ☐ Orange ☐

Health Care Card / Pension Number: ………………………………………………. Expiry ………/……….

Concession card type: ☐ Pensioner Concession Card ☐ Health Care Card

Next of Kin: (if different from above emergency contact)

Name:………………………………………………………………… Contact Number:…………………………………

Relationship to you:……

Emergency Contact Details:

Name:………………………………………………………………… Contact Number:…………………………………

Relationship to you:……

Please advise us if your contact information or Medicare details change

Hawkins Clinic
GENERAL MEDICAL PRACTICE
30 Sturt Street Mount Gambier South Australia

Transfer of Health Information

You may have consistently consulted with a GP at another practice. The health information held by that GP may assist us with your future health care needs. You may wish to have a copy or a summary of your health records transferred to this practice. Please ask the receptionist/office staff for information about completing a Patient File Transfer Request form.

Your Health History- do you have or have you had a history of:

Please circle	Description	Details (including date for operations)
Yes/No	Operations	Details:________________________________ Date: __________ Details:________________________________ Date: __________ Details:________________________________ Date: __________ Details:________________________________ Date: __________ Details:________________________________ Date: __________ Details:________________________________ Date: __________
Yes/No	Asthma	
Yes/No	Diabetes	
Yes/No	Hypertension	
Yes/No	Chronic Illness	
Yes/No	Other	

Immunisations- have you had the following immunisations:

Immunisation	Date	Circle if you are unsure or haven't had one	
Tetanus booster		Unsure	Haven't had one
Hepatitis A		Unsure	Haven't had one
Hepatitus B		Unsure	Haven't had one
Influenza		Unsure	Haven't had one
Pneumococcal pneumonia		Unsure	Haven't had one
Polio		Unsure	Haven't had one
Gardasil, 1		Unsure	Haven't had one
Gardasil, 2		Unsure	Haven't had one
Gardasil, 3		Unsure	Haven't had one

Children's Immunisations:

If you are completing this form for a child, are their immunisations up to date?

Yes **No** (please circle)

Current Medications: (including over the counter medications, vitamins and minerals)

___________________________________ ___________________________________
___________________________________ ___________________________________
___________________________________ ___________________________________
___________________________________ ___________________________________
___________________________________ ___________________________________
___________________________________ ___________________________________

Allergies

____

____

Females- when did you last have a:

Pap Smear	Date:___________	Unsure	Never
Breast Check/Mammogram	Date:___________	Unsure	Never

Males- when did you last have:

An overall check-up	Date:___________	Unsure	Never

Other- when did you last have a:

Bone Density Test	Date:___________	Unsure	Never
Colorectal Cancer Screening	Date:___________	Unsure	Never

Social History:

Smoking

Never Smoked Smoking ………. per day/week Ceased Smoking……….(year)

Alcohol

I do not drink alcohol I consume…………. per day / week / month

Recreational Drug Use

Type and frequency……………………………………………………………………………………………………

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Family History: have any members of your family been diagnosed with or suffered from:

Diagnosis	Family member
☐ Diabetes	
☐ Asthma	
☐ Heart Disease	
☐ Mental Illness	
☐ Cancer	

Is there is any other information that you believe we should know that may affect or have an influence on the medical treatment / advice you will be provided with? If **Yes**, please provide details below:

____

____

____

____

Signature of patient or guardian:……………………………………………………………………Date: / /

Thank you for completing this form- please give it to your Doctor during your first appointment