Our Family, Caring for Yours!

GENERAL MEDICAL PRACTICE

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.*

Gender:………………………………………………… Preferred Pronouns……………………………………….

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

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/Children's Immunisations:

Please sign below to indicate permission for the clinic to access the Australian Immunisation Register to obtain your/your children's Immunisation History.

Sign:……………………………………………………………………… Date:………………………………

<u>Current Medications:</u> (including over the counter medications, vitamins and minerals)

___________________________________ ___________________________________
___________________________________ ___________________________________
___________________________________ ___________________________________

___________________________________ ___________________________________
___________________________________ ___________________________________
___________________________________ ___________________________________

Allergies

____

____

<u>Females</u>- when did you last have a:

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

<u>Males</u>- when did you last have:

An overall check-up	Date:___________	Unsure	Never

<u>Other-</u> when did you last have a:

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

<u>Social History:</u>

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………

Our Family, Caring for Yours!

GENERAL MEDICAL PRACTICE

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