New Patient Registration

We are committed to providing our patients with the best care. To do this it is essential that your health record is up to date and accurate.

Please complete the following and return to reception.

☐ **Mr** ☐ **Mrs** ☐ **Ms** ☐ **Miss** ☐ **Mast** ☐ **Other** ____________			
Surname			
First Name		**Middle Name**	
Preferred Name		**Date of Birth**	
Birth Sex ☐ **M** ☐ **F** ☐ **Other** ____________		**Gender Identity** ☐ **M** ☐ **F** ☐ **Other** ____________	
Marital Status ☐ **Married/Defacto** ☐ **Single** ☐ **Other** ____________			
Residential Address			
Postal Address			
Home Phone		**Work Phone**	
Mobile Phone			
Do you consent to receiving SMS messages? ☐ Yes ☐ No **Do you consent to receiving email correspondence?** ☐ Yes ☐ No			
Email			
Medicare Number		**Ref. No.**	**Expiry Date**
Pension Number		**Expiry Date**	
HCC Number		**Expiry Date**	
DVA ☐**Gold** ☐ **White**		**Expiry Date**	
Next of Kin Name/phone/relationship			
Emergency Contact Name/phone/relationship			

To assist with health initiatives please advise your ethnicity:

☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal & Torres Strait Islander

☐ Australian ☐ Other – please state ______________________________________

Is English your first language? If not, do you require an Interpreter? Please specify language

Yes ☐ No ☐ Yes ☐ No ☐ _________________________

YOUR HEALTH HISTORY - do you have or have you had a history of?

☐ Operations (please list details including year)

____

____

-

____

☐ Asthma

____

☐ Diabetes

____

☐ Hypertension (high blood pressure)

____

☐ Chronic illness (e.g. heart disease)

____

☐ Have you had an eye check in the last 2 years?

____

☐ Other

____

Do you have any allergies or are you sensitive to drugs or dressings:

☐ Yes (please list below) ☐No

____

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

____

____

____

Social history

☐ Tobacco _________ daily / weekly or Ceased Smoking - date ________________

☐ Alcohol _________ daily / weekly / monthly (circle applicable)

☐ Drug use ____ (type and frequency)

Height__________ __________ cms **Weight**_________________________ kgs

For those 65 years and older: when was the last time you had:

Influenza vaccine Date_____________ ☐ not sure ☐ never

Pneumococcal pneumonia vaccine Date_____________ ☐ not sure ☐ never

Females: When did you last have?

Cervical Screening Test (Pap Smear) Date_____________ ☐ not sure ☐ never

Males: When did you last have?

An overall check up Date _____________ ☐ not sure ☐ never

By signing this document, you are consenting to the release and receiving of medical information **relevant to your care and treatment** between health service providers. Please advise reception if you do not want medical information released or received by this clinic.

Date_____________________**Signature**__-
____