

PATIENT REGISTRATION FORM

Title: Mr Mrs Ms Other: _____

Surname: _____

First name: _____
(On Medicare card)

Preferred name: _____

Date of birth: _____

Gender: Male Female

Country of birth: _____

Home address: _____

Town / Suburb: _____ Postcode: _____

Telephone: Home: _____ Work: _____ Mobile: _____

Email: _____

Health Care Card.: _____ Expiry Date: _____

Pension Card.: _____ Expiry Date: _____

Senior Card No.: _____ Expiry Date: _____

Medicare number: _____

Line No (e.g 1, 2, 3): _____ Expiry Date: _____

Veterans' Affairs number and Card Type (gold or white): _____ Expiry Date: _____

<p>PARENT DETAILS (If registering a child)</p> <p>First name: _____</p> <p>Surname: _____</p> <p>Date of birth: _____</p> <p>Medicare No: _____</p> <p>Expiry Date: _____</p>
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Do you identify yourself as Aboriginal or Torres Strait Islander: Yes / No (please circle one)

NEXT OF KIN

Name: _____

Phone: _____

Address: _____

Relationship: _____

EMERGENCY CONTACT Same as Next to Kin

Name: _____

Phone: _____

Address: _____

Relationship: _____

MEDICAL HISTORY

Past medical history: _____
E.g Asthma, Diabetes - (Conditions / illnesses)

List of Past Surgeries and When: _____
(E.g Appendix removed in 2014)

Current medications: _____
(Note name / dose / frequency)

Allergies/Reactions: _____

Family medical history: _____

Smoker: Yes _____ (number per day) No Ex-smoker (Year stopped _____)

Alcohol: Yes _____ (How often) No

Yes _____ (How many)

Are you up to date with the following:

Pap Smear (every 2 years)	No/Yes/NA	<u> MM/YY </u>	(Please circle one & provide date)
Skin Check (every 1 year)	No/Yes	<u> MM/YY </u>	(Please circle one & provide date)
Bowel Screening (every year if over 50)	No/Yes/NA	<u> MM/YY </u>	(Please circle one & provide date)
Mammogram (every 2 years if over 50)	No/Yes/NA	<u> MM/YY </u>	(Please circle one & provide date)

Patient's Signature

____/____/____
Date

ABOUT YOUR INFORMATION AND OUR PRACTICE (USE OF HEALTH DATA FOR RECALL REMINDER SYSTEM & QUALITY IMPROVEMENT)

The personal information you provide during your consultation and subsequent treatment will be collected for the sole purpose of providing high quality healthcare. This practice is committed to protecting your privacy and this information is only disclosed to other members of your treating team where medical necessary. It may however be disclosed to organization where required by law.

This practice uses a recall reminder system & engages in ongoing clinical quality improvement. To do this, access to your de-identified medical information is necessary. This information has no name, date of birth, nor any other identifying features if it is used for clinical audits or medical practice quality assessments. Privacy & confidentiality of your medical record is maintained at all times. The practice uses SMS's for reminder and information purposes.