New Patient Registration Form

DOB:____/_____/___ **MALE / FEMALE/OTHER** (please circle)

Title: MR MRS MISS MAST MS DR OTHER _____

Surname: _____ **First Name:** _____

Middle Name: _____ **Preferred Name:** _____

Address: _____

Suburb: _____ **State:** _____ **Postcode:** _____

Mobile Number: _____ **Home Number:** _____

Work Number: _____ **Email:** _____

Next of Kin: *(Best person for us to contact in an emergency)*

Name: _____ **Relationship:** _____ **Phone:** _____
Address: _____

Emergency Contact: *(Should be different to the Next of Kin)*

Name: _____ **Relationship:** _____ **Phone:** _____
Address: _____

Medicare Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ **Ref:** _____ **Expiry** _____

Pension / Concession Number: _____ **Expiry** _____

Dept. of Veterans Affairs: _____ **Expiry** _____

Marital Status: Married / De facto / Single / Widowed / Separated / Divorced

Do you Identify as: Aboriginal / Torres Strait Islander / Both / Neither

Ethnicity & Cultural Background: _____

Occupation: _____

OUR PRACTICE USES SMS FOR APT REMINDERS AND RECALLS. IF YOU DO NOT WANT TO RECEIVE THESE PLEASE INFORM OUR PRACTICE

~ This Practice prides itself on quality health care. As part of our commitment to providing optimal care all new patients are seen by one of our practice nurses prior to the first consult with GP. ~ I agree that this information is accurate and true to the best of my understanding and that there is no other information that I believe the practice should know that may affect / or have an influence on the medical treatment / advice I will be provided with.

Date:_____ Name: _____ Signature:_____

Optional: I authorise the following person(s) to take messages regarding recalls, reminders and changes of appointments**:**
Name: _____ Relationship: _____
Signature to authorise the above: _____

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Previous Medical History

Allergies and Sensitivities: YES / NO - If yes, please list

_____

_____

Serious and Ongoing Illnesses (eg. Asthma, Diabetes etc) **YES / NO - If yes, please list**

_____

_____

Any Operations: YES /NO - If yes, please list

_____

_____

Do you take any medications? YES / NO - If yes, please list

_____

_____

Family History: Do you have any close family member with the following:

Diabetes		**Heart Disease**		**COPD**	
Asthma		**Cancer:** *(State Type)*			
Other Illness:					

Female Patients: When did you last have a:

Pap Smear	Date:	Never		Not Sure	
Breast Check	Date:	Never		Not Sure	
Mammogram	Date:	Never		Not Sure	

Were any of the above abnormal? Yes / No – If yes, please elaborate**:**

_____

Male Patients over 50y/o: When did you last have a:

Bowel Cancer Screening	Date:	Never		Not Sure	

Was the above result abnormal? Yes / No – If yes, please elaborate**:**

_____

Alcohol:

Do you consume Alcohol? Yes / No - If yes: Daily / Weekly / Monthly

In one day how many standard drinks would you consume? ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-9 ☐ 10 +

Tobacco: ☐Never smoked ☐Ceased Smoking in what year _____ ☐Currently Smoke __ per day/wk

Exercise: How many days a week do you exercise?

☐ 1 day ☐ 2 days ☐ 3 days ☐ 4 days ☐ 5 days ☐ 6 days ☐ 7 days ☐ Never