patient registration form

We would like to get to know you and help you to live a healthy life. To do this, we need to learn more about your health and the best ways to communicate. The more that you can tell us, the more that we can help. Your information will be treated in strict confidence.

Contact details

Title: Given names: Surname:

Known as: DOB: Gender: M □ F □ Transgender □

Address:

Email address:

Contact numbers: Home Work Mobile

Other contact details

Next of kin: Given names Surname

Contact number/s: Relationship:

Emergency contact (If different): Given names Surname

Contact numbers: Relationship:

Account contact (If different): Given names Surname

Address:

Contact numbers: Relationship:

Medicare card: Ref Expiry Date Eligible for concession: Yes □ No □

Personal details (optional)

Marital status: Religion: Occupation:

Cultural details

Do you identify as: Aboriginal □ Torres Strait Islander □ Both Aboriginal and Torres Strait Islander □ Neither □

Ethnicity: Country of birth: Year of Arrival:

Spoken Language/s: Preferred Language: Interpreter: Yes □ No □

Refugee or asylum seeker: Yes □ No □ Settlement Case Manager: Ph:

How did you find out about us?

Consent

We take an active approach to your health and use different ways to communicate with you for various reasons

Do you give us permission to:

- record your health information for medical and health related services? Yes □ No □
- disclose your health information to other health care providers involved in your treatment? Yes □ No □
- record and use your personal information for billing and administrative purposes? Yes □ No □
- call you to confirm upcoming appointments? Yes □ No □
- send you SMS reminders for upcoming appointments? Yes □ No □
- contact you regarding matters involving your health as part of our follow-up system? Yes □ No □
- send you emails or letters about upcoming health related opportunities at our practice? Yes □ No □

I (Patient / Guardian Name) agree that this information is accurate and true to the best of my understanding and that there is no other information that would influence the medical treatment or advice to be provided.

Signature _____ Date Patient □ Guardian □

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patient history form

active medical

Medical history

Do you have any allergies to medicines or are you sensitive to any dressings?

No □ Yes □ (please list)

Are you currently using any prescribed or over the counter medications or vitamins and minerals?

No □ Yes □ (please list)

Do you have or have you ever had a history of:

Heart problems	No □	Yes □	Migraines	No □	Yes □
High blood pressure	No □	Yes □	Asthma, respiratory problems	No □	Yes □
Kidney, bladder problems	No □	Yes □	Skin rashes, dermatitis, eczema, psoriasis	No □	Yes □
Emotional disorder, anxiety, depression	No □	Yes □	High cholesterols	No □	Yes □
Fits, strokes, epilepsy	No □	Yes □	Liver disease, jaundice, hepatitis	No □	Yes □
Varicose veins, clots, blocked arteries	No □	Yes □	Sinus problems	No □	Yes □
Stomach ulcers	No □	Yes □	Ear or hearing problems	No □	Yes □
Eye or vision problems	No □	Yes □	Serious trauma, major operations	No □	Yes □
Back, neck, joint problems	No □	Yes □	Sexual dysfunction	No □	Yes □
Bowel, rectal problems	No □	Yes □	Abnormal pap smear	No □	Yes □
Prostrate problems	No □	Yes □	Sexually transmitted disease	No □	Yes □
Thyroid problems	No □	Yes □	HIV	No □	Yes □
Sickle cell anaemia, thalassaemia	No □	Yes □	Cancer	No □	Yes □
Diabetes	No □	Yes □	Type	Diagnosis date	

Preventative health

When was your last check for the following:

Cholesterol	Date	Not sure □	Never □
Blood pressure	Date	Not sure □	Never □
Fasting sugar	Date	Not sure □	Never □
HIV	Date	Not sure □	Never □

Male

Prostate	Date	Not sure □	Never □

Female

Pap/Cervical	Date	Not sure □	Never □
Breast check	Date	Not sure □	Never □
Mammogram	Date	Not sure □	Never □

Immunisation history *If this record is for a child, please also provide immunisation record book at your first appointment.*

Tetanus	No □	Yes □	Not sure □	Measles	No □	Yes □	Not sure □
Chicken pox	No □	Yes □	Not sure □	Polio	No □	Yes □	Not sure □
Hepatitis A	No □	Yes □	Not sure □	Hepatitis B	No □	Yes □	Not sure □
Rubella	No □	Yes □	Not sure □	Meningococcal	No □	Yes □	Not sure □
Influenza	No □	Yes □	Not sure □	Pneumococcal	No □	Yes □	Not sure □

Family history

Have any of your direct relatives ever had:

High cholesterol	No □	Yes □	Heart disease	No □	Yes □
Stroke (brain)	No □	Yes □	Sickle cell anaemia, thalassaemia	No □	Yes □
Depression, schizophrenia	No □	Yes □	Asthma, respiratory problems	No □	Yes □
Emphysema	No □	Yes □	Diabetes	No □	Yes □
Thyroid problems	No □	Yes □	Bowel problems	No □	Yes □
Kidney disease	No □	Yes □	Skin rashes, dermatitis, eczema, psoriasis	No □	Yes □
Cancer	No □	Yes □	Other (please specify)		

Social history

Do you exercise?	No □	Yes □	how many times per week?	Duration of exercise?	
Do you smoke?	No □	Yes □	how often?	Smoking for how many years?	
Do you drink alcohol?	No □	Yes □	how many days per week?	Number per occasion?	
Do you use recreational drugs?	No □	Yes □	how often?	What type?	

OFFICE USE ONLY Team member: _____ Date: _____

Identification verified: known to team member □ licence □ passport □ other _____

Medicare called to check item number eligibility □ Date: _____ Time: _____ Name of Medicare officer: _____

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