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| **PATIENT INFORMATION****First name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Surname/Last name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Preferred name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Date of Birth : \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_ Salutation :** Mr Ms Miss Mrs Mast **Sex** : M F**Marital status:**  Single  Married  Divorced  Widowed  **DO YOU OR YOUR FAMILY IDENTIFY AS BEING ABORIGINAL OR TORRES STRAIT ISLANDER Yes No** **Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Suburb: \_\_\_\_\_\_\_\_\_\_\_** **Postcode: \_\_\_\_\_\_\_\_\_\_\_****Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SMS booking reminder: YES NO** **Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Country of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Medicare Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ref: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiry: \_\_\_\_\_/\_\_\_\_\_\_****Health Care card / Pension No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiry: \_\_\_\_/\_\_\_\_/\_\_\_\_\_****Senior Card No:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****MEDICAL HISTORY****Current Weight: \_\_\_\_\_\_\_\_\_Kg Height \_\_\_\_\_\_\_\_\_\_\_cm****Do you or have you ever suffered any of these medical conditions?****If yes please tick- Diabetes Asthma High Blood Pressure**  **Cholesterol Arthritis Cancer**  **Heart Problems** **Major Operations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Do you Smoke?** **NO**  **YES** **Do you drink Alcohol? Never Occasional Moderate Heavy** **Any other Health Problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Do you have any allergies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Current medications, (please include over the counter medications, vitamins & minerals)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**PATIENT REGISTRATION FORM**

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| **FAMILY MEDICAL HISTORY****Is there any family history of the following conditions?****If yes please tick:** **Diabetes Mother Father other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Asthma Mother Father other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****High Blood Pressure Mother Father other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Cholesterol Mother Father other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Arthritis Mother Father other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Heart Problems Mother Father other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Cancer Mother Father other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Colon cancer**  **Mother Father other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Depression**  **Mother Father other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Stroke** **Mother Father other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Breast cancer Mother Father other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Mother alive? YES  NO** **Father alive? YES  NO**  |

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| **IN CASE OF AN EMERGENCY****Next of Kin****Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Name of a local friend or relative (not living at same address)****Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

RECALL/REMINDERS: Our Practice provides our Patients with preventative care and early case detection reminders. Example: Immunisations, annual health checks and pap smears. By signing this Patient Information Form you are therefore in agreement with receiving such notifications.

I certify that all answers provided are true and correct to the best of my knowledge.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_\_

“This practice is committed to maintaining the confidentiality of your personal health information. Your medical record is a confidential document. It is the policy of this practice to maintain security of personal health information at all times and to ensure that this information is only available to authorised members of staff”.