NEW PATIENT REGISTRATION FORM

We are committed to providing our patients with the best care, to do this it is essential that your medical records are up to date and accurate. Could you please assist us by completing the following?

	☐ Mr Mrs Ms Master Miss Dr Prof Other_____ Given Name: _____ Surname: _____
Date of Birth:	/ / M/F
Residential Address: (if different from below)	
Postal Address:	
Ethnicity Status:	Aboriginal Y ( ) No ( ) Any other Ethnic Group Y ( ) No ( ) Torres Strait Islander Y ( ) No ( ) Please Specify _____
Contact Numbers:	Home: _____ Work: _____ Mobile: _____
Medicare Number:	Ref No: __ __ __ __ __ __ __ __ __ __ Line No:_____ Exp: _____ /_____
DVA Number	_____ EXP:_____ GOLD ( ) WHITE ( )
Health Care Card /Pension Card	__ __ __ __ __ __ __ __ __ __ EXP: _____ HCC ( ) PENSION ( )
Next of Kin: Emergency Contact:	Full Name Relationship: Contact No: __ __ __ __ __ __ __ __ Full Name: Relationship: Contact No:__ __ __ __ __ __ __ __ **Do you give consent for us to provide information relating to your medical history to a family member, YES ( ) No ( )** (This does not apply for patients under the age of 15) Name: Relationship: Contact No: __ __ __ __ __ __ __ __

Do you consent for the clinic to send a Recall (Follow Up Appointment) SMS Reminder via your mobile phone YES ( ) NO ( )
Do you consent for SMS reminder's for any future appointments via your mobile phone **YES ( ) NO ( )**
Do you consent for us to leave a message on your voice mail/answering machine **YES ( ) NO ( )**
There may be a need for our Allied Health Professionals (ie Psychologists, Dietitians, Podiatrists etc) to access your Medical details. Do you consent for this **YES ( ) NO ( )**

Policies & Procedures

Compensation accounts: This practice does not issue accounts for consultations regarding third party/workers compensation cases, full payment will be required at the time of the consultation. A reminder that patients who are under workers compensation or Motor Vehicle accident Insurance are responsible for all accounts incurred.

Non Attendance/Short Notice Cancellation Fees: This practice requires a minimum 3 hours notice for cancellation of appointments. Short notice cancellation or failure to attend your appointment may result in a **non-rebatable** fee.

SIGNED_____ DATE_____

STAFF USE ONLY: Initials _____ Date: _____

NAME .....DOB: .....

CURRENT WEIGHT_____ CURRENT HEIGHT_____

ALLERGIES

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

YES ( ) NO ( )

Details:_____

FAMILY HISTORY – Do you have any relevant family history eg: Diabetes?

YES ( ) NO ( )

Details:_____

SOCIAL HISTORY:

- Do you smoke YES ( ) NO ( ) Never ( ) Ceased smoking date: _____
- Alcohol YES ( ) NO ( ) if yes how many standard drinks per week? _____
- Drug use: _____(Type and frequency)

PAST MEDICAL HISTORY

OPERATIONS? _____

Hypertension (Blood Pressure) Yes ( ) No ( ) Diabetes approx date diagnosed _____

Asthma: approx date diagnosed _____ Other/s _____

OVER 65 YEARS : When was the last time you were immunized?

Influenza Date:_____ Unsure: ( ) Never ( )

Pneumococcal pneumonia Date: _____ Unsure: ( ) Never ( )

FEMALES ONLY: When did you last have?

Pap Smear Date: _____ Unsure ( ) Never ( )

Breast Check Date: _____ Unsure ( ) Never ( )

MEN ONLY: When did you last have?

An overall check up Date: _____ Unsure ( ) Never ( )

CHILDRENS IMMUNISATIONS: - If completing this form for a child is their immunization up to date?

YES ( ) NO ( ) UNSURE ( )

CURRENT MEDICATIONS: _____

_____

Your privacy is very important to us. 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 authorized members of staff. The information collected in this form will be kept confidential at all times. All staff employed at this clinic are bound by a confidentiality agreement in accordance with accreditation standards. A copy of our privacy policy is available at the front desk.

STAFF USE ONLY: Initials _____ Date: _____