Heathmont General Practice
New Patient Registration

****When you register as a patient of our practice, you provide consent for our GPs and practice staff to access and use your personal information so they can provide you with the best possible healthcare. Only staff that need to see your personal information will have access to it. If we need to use your information for anything else, we will seek additional consent from you to do this.**

***PLEASE SIGN: ……Date: ……..**

Personal Details:

Miss/Ms/Mrs/Mr/Master/Other …… Date of Birth: ……

First Name: …… Surname: ……

Address: ……

Phone: …… Mobile: …… Email: ……

Ethnicity: * *(please circle one – if you select other, please state your ethnicity)*

Aboriginal Torres Strait Islander Australian (non indigenous) * Other……

Do you have a MyHr (My Health Record)? (*Please circle*)

YES I do have one **OR** **NO I have opted out**

Employer: …… Phone: ……

Occupation: ……

Medicare Details:

Medicare Number: …… Reference Number: …… Expiry Date: ……

Do you own any of the following cards? *(please circle one)*

Pension Yes / No Card Number: …… Expiry Date: ……

Health Care Card Yes / No Card Number: …… Expiry Date: ……

DVA – White/Gold Yes / No Card Number: …… Expiry Date: ……

Private Health Insurance:

Do you have Private Health Insurance? Yes / No *(please circle)*

Name of Fund: …… Membership Number: ……

Workcover/TAC: *(please circle)*

Is your appointment today related to a Workcover claim? Yes / No Claim No. ……

Is your appointment today related to a TAC claim? Yes / No Claim No. ……

How did you hear about us? *(please circle one- if select other, please state)*

Google Family Referral Other……

Please turn the page >>

Patient Medical Information

Do you have a history of any of the following?

History	Year		Other medical history or operations	Year
☐ Hypertension ☐ Diabetes ☐ Heart Attack ☐ Asthma ☐ Epilepsy ☐ Stroke ☐ High cholesterol ☐ Cancer ☐ Mental Illness				

Do your family members have any of the following?

Family History	Which Family Member(s)	Other Family History
☐ Hypertension ☐ Cardiovascular Disease ☐ Stroke ☐ Diabetes ☐ Breast Cancer ☐ Bowel Cancer ☐ Depression		Mother Father Siblings Children Other

Do you have any allergies to medications, foods, tapes etc?

Allergy	Type of Reaction

Current Medications	Dose	Frequency

***LAST PAP SMEAR: (approx. date) .....**

Have you ever had a Mammogram? Yes / No / N/A When? …….

Have you ever had a colonoscopy? Yes / No When? …….

SMOKING:

☐ Never Smoked ☐ Ex-smoker - Year of quitting _____ ☐ Smoker _____cigarettes/day Year started _____

ALCOHOL:

☐ Non Drinker ☐ Drinker No/ of days/ week _____No/of drinks/day _____Type of drink _____

Next of Kin		Relationship	
Address		Phone: Mobile:	
Alternate Contact (**not NOK**)		Relationship	
Address		Phone: Mobile:	