New Patient Registration

Personal Details:

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

Birth sex: (please circle) Female Male Other

Gender identity: (please circle) Female Male Non-Binary Transgender Gender diverse

Pronouns: (please circle) She/Her/Hers He/Him/His They/Them/Theirs

First Name: ……..…… Surname: …..……..……..……..

Address: ……

Phone: ……..…… Mobile: ……. ……..…… Email: ……..……..

Ethnicity: (please circle one) Aboriginal Torres Strait Islander Australian (non indigenous)

Cultural background: ……

Current occupation: ……

Employer: ……..…….. **Phone**: ……..

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

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

***PLEASE SIGN: ……Date: ……**

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. **(We use POLAR GP software to share de-identified information to our local primary health network to improve health services in the area. Please advise the Practice Manager if you do not wish for your information to be included) *

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 Cervical Screening: (approx. date) ……..…… (If applicable)**

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

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

SMOKING STATUS:

☐ Non-Smoker ☐ Ex-smoker – Yr. stopped _____

☐ Current Smoker, cigarettes p/day _____ Year started _____

ALCOHOL INTAKE:

☐ Non-Drinker, ☐ Drinker- No. of days p/wk. _____, No. of drinks p/day _____, Type of drink _____

Next of Kin			**Alternative contact** (not NOK)	
Relationship			Relationship	
Mobile Phone			Mobile Phone	
Address			Address	