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)**

Do you consent for appropriate staff to access the National Cancer Screening Register to determine reminder status for cervical and bowel screening? Yes / No

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	