Inactive

Robinson Street Medical Centre

New Patient Registration Form

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

Title (SPECIFY)		PRONOUN: SHE/HE/THEY	GENDER: MALE/FEMALE/SELFIDENTIFIED
SURNAME			DATE OF BIRTH
GIVEN NAMES			
ADDRESS			
HOME PHONE		WORK PHONE	
MOBILE		EMAIL	
MEDICARE NUMBER		REF:	EXP:
DVA NUMBER		WHITE / GOLD:	
PENSION NUMBER		EXP:	
EMERGENCY CONTACT DETAILS			
NAME			
ADDRESS			
RELATIONSHIP		PHONE NUMBER	
NEXT OF KIN			
NAME			☐ AS ABOVE
ADDRESS			
RELATIONSHIP		PHONE NUMBER	
IF PATIENT IS A CHILD, COMPLETE DETAILS OF PERSON RESPONSIBLE FOR THE ACCOUNT			
NAME		DATE OF BIRTH	
ADDRESS			
PHONE NUMBER			
PATIENT RESPONSIBILITIES			
I UNDERSTAND THAT IN SIGNING THIS FORM:			

- I am consenting to my medical information being released to a third party, such a specialist or pathology laboratory and for access to MY HEALTH RECORD in the course of my medical care.
- I can authorise another individual to obtain test results on my behalf. (Optional)
- Obtaining results from any medical tests or procedures will remain my responsibility.
- It is my responsibility to notify the practice of any changes to my personal details.
- I understand my Patient Health Identifier Number (HIN) will be obtained from Medicare.
- I consent to being contacted via SMS Message for the purpose of health and appointment reminders.
- I confirm that I have received a copy of the Practice Privacy Policy.
- I agree that any payment required will be paid on the day of my consultation.

Signed: Date:

PERSONAL DETAILS			
OCCUPATION:			
Country of Birth:			
Ethnicity/Nationality/Family Background			
Will you require an interpreter?	Yes ☐	No ☐	Preferred Language:
Are you of Aboriginal descent?	Yes ☐	No ☐	
Torres Strait Islander descent?	Yes ☐	No ☐	

MEDICAL DETAILS
PLEASE SUPPLY DETAILS OF THE FOLLOWING, WITH DATES WHERE POSSIBLE
PREVIOUS ILLNESSES:
PREVIOUS INJURIES:
PREVIOUS OPERATIONS:
ANY REGULAR MEDICATIONS, INCLUDING NON-PRESCRIPTION, VITAMINS, HERBAL PREPARATIONS:
DOES ANY MEMBER OF YOUR FAMILY SUFFER FROM DIABETES, HEART DISEASE, CANCER, OTHER?
DO YOU HAVE ANY ALLERGIES OR ARE YOU SENSITIVE TO DRUGS OR DRESSINGS?
☐ NO KNOWN ALLERGIES ☐ YES - PLEASE LIST

LIFESTYLE			
DO YOU SMOKE?	☐ YES (Number per day.......)	☐ No	☐ EX-SMOKER (Year stopped ……..)
ALCOHOL INTAKE	DAYS PER WEEK __________		STANDARD DRINKS PER DAY ___________

IF YOU ARE OVER 40
WHEN WAS YOUR LAST GENERAL HEALTH CHECK? (Blood pressure, cholesterol etc.)

DO YOU HAVE?	
An advance health directive for end of life care? ☐ Yes ☐ No	An existing Chronic Disease Management Plan? ☐ Yes ☐ No
IF COMPLETING THIS FORM FORA CHILD, ARE THEIR IMMUNISATIONS UPTO DATE: YES / NO	
DETAILS ENTERED:	Staff Initials: DOCTORS SIGNATURE:

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