NEW PATIENT REGISTRATION FORM

TITLE: (please circle) Prof, Dr, Mr, Mrs, Miss, Ms, Master

First Name: ………………………… **Middle Name:** ………………………… **SURNAME:** ……………………………………..

Gender Identity: ………………………………….. **Pronoun:** He/ Him She/Her They/ Them

Likes to be known as: ………………………… **Date of Birth:** …………………………… **Gender:** Male / Female

Do you identify as Aboriginal or Torres Strait Islander origin?
No Yes –Aboriginal Yes -Torres Strait Islander Yes -both Aboriginal & Torres Strait Islander(please circle)

Country of origin : ………………………………………………

ADDRESS					
Home ☏		**Work ☏**		**Mobile ☏**	
Email 💻					
Preferred Method of Contact	SMS	Email	Home phone	mobile phone	

Medicare Number	**Reference No. (No. you are on the card)**	**Expiry Date**
__ __ __ __ __ __ __ __ __ __	__	__ __ /__ __ __ __
Concession Card Number	**Type of Concession**	**Expiry Date**
	Pension Health Care *Veteran Affairs: Gold / White / Orange*	

Name of Next of Kin: ……………………………………**Phone:** ………………………**Relationship:**……………………………

Do you want this person contacted in case of an emergency? Yes/No

If No, who is your emergency contact? Name: …………………………………… Number: ………………………………

If under 16 years of age – person to contact on your behalf:…………………………………………

Relationship of that person:…………………………………………………………………

What is your preferred language if not English? ……………………… **Do you require an interpreter?** Yes/No

As a patient of this practice I consent to:

- ☐ Being added to the recall system for the purpose of results, recall reminders & being contacted.
- ☐ Being responsible for updating my contact details as they change (address & phone numbers)
- ☐ Consent to sharing of shared health summaries through my health record
- ☐ Receiving reminder SMS/email messages for booked appointments, results received & notifications
- ☐ I assign my rights to benefits to the practitioner who renders my service where possible (bulk bill)

You MUST tick the above boxes to acknowledge these policies

Patient/Guardian Signature: ……………………………………………… **Date:** ……………………………………

Office use only: Photo/Medicare ID checked:_______ Initial; Best Practice entry:____ Scanning :____

PLEASE COMPLETE AND SUBMIT TO YOUR GP

Name .... **DOB:** ....

Marital Status	Single	Married	Defacto	Separated	Widowed

Family medical history - Mother	***Family medical history - Father***
Diabetes Hypertension Heart disease Stroke Colon cancer Depression Breast cancer Other:...	*Diabetes Hypertension Heart disease Stroke Colon cancer Depression Other:*...
Social History (eg hobbies, children or grandchildren)	
Have you been a member of the Australian Defence Force? Yes/No	

Known ALLERGIES	***Reaction***

Your Health

High/ Low blood pressure (specify)	Yes	No	Maybe
Osteoporosis / Arthritis (specify)	Yes	No	Maybe
Angina	Yes	No	Maybe
Heart Murmur	Yes	No	Maybe
Heart Surgery	Yes	No	Maybe
Other heart disorder	Yes	No	Maybe
Blood Disorder	Yes	No	Maybe
Leukaemia	Yes	No	Maybe
Bleeding Disorder	Yes	No	Maybe
Diabetes	Yes	No	Maybe
Liver Disease	Yes	No	Maybe
Kidney Disease	Yes	No	Maybe
Women- May you be pregnant?	Yes	No	Maybe
Women- Any Past Pregnancies?	Yes	No	

If Yes, DOB:...

DOB:...

Blood Group (if known) ....

Epilepsy	Yes	No	Maybe
Cancer	Yes	No	Maybe
If Yes, what type...			
Depression/Anxiety (specify)	Yes	No	Maybe
Immune System Disorders	Yes	No	Maybe
Visual Impairment	Yes	No	Maybe
Hearing Impairment	Yes	No	Maybe
Respiratory: Asthma	Yes	No	Maybe
COPD	Yes	No	Maybe
Emphysema	Yes	No	Maybe
Other	Yes	No	Maybe
Previous Operations	Yes	No	

If Yes, what type & year:...

type & year:...

type & year:...

Anything Other than listed: ....

Are your immunisations up to date? (please circle) Yes / No / Unknown

For over 13 years only		
Never Smoked	**Smoker** How many per day? Year Started:	Ex Smoker – Congratulations! Quit Date:

Alcohol	Non drinker		Occasional Drinker	
	How many days per week do you drink alcohol?		How many standard drinks do you consume?	

*Please be advised, on your **FIRST** consultation, this practice will not as part of our policy:*

1. *Prescribe drugs of addiction (schedule 8) such as Valium, Oxycondone, pain patches or any similar medications.*
2. *Complete forms for Centrelink, insurance companies or any form requiring full and complete medical history.*
3. *Drivers licence medical assessments.*

Patient/Guardian Signature: .... **Date:** ....

Doctors Signature: .... **Data entered in patients file: YES NO**

WeCare Health
Where care comes first