Name: *D.O.B.:*

New patient registration

We are committed to providing our patients with the best care. Therefore, please assist us be completing the following questions, to ensure your health record is accurate. Where applicable, please circle your selected response. *Thank-you.*

1 Personal details

Title: *Dr* *Mr* *Mrs* *Ms* *Mst.* *Miss* *Other*

Surname:

Given name:

Preferred name:

Date of birth: / / *Gender: Female / Male*

Address:

Street:

Suburb: *Postcode:*

Is your postal address the same as above: Yes / No *If no, please list below:*

Suburb: *Postcode:*

Contact numbers: *Home:* *Work:*

Mobile:

Do you consent to SMS reminders: Yes / No *Preferred number: Home / Work / Mobile*

eMail address:

Occupation: *Recreational activities:*

Do you have a Personally Controlled eHealth (PCEHR) Record? *Yes / No*

If no, would you like to register? Yes / No *If yes, please see a Reception team member.*

Name: *D.O.B.:*

Medicare: *Card number:*
Reference number: *Expiry:*

Health care card or pension card:
Reference number: *Expiry:*

DVA card number:
Card colour: *Expiry:*

Private health cover: *Fund name:* *Number:*

Are you of Aboriginal or Torres Strait Islander origin? *Yes / No*

Do you identify as someone from a culturally and / or linguistic diverse background? *No* *Yes - please elaborate (country):*

Interpreter required. *If yes, please specify language / dialect:*

How did you hear about us?

	Family / Friend		*Westfield Garden City Shopping Centre*
	Newspaper		*Garden City Medical Centre Flyer / Brochure*
	Facebook		*Other*

2 Next of kin / emergency contact

Name: *Relationship to you:*

Address:
Suburb: *Postcode:*

Contact numbers: *Home / Work:* *Mobile:*

Is the person you listed as your next of kin, also your emergency contact: Yes / No

If no, please list your emergency contact below:

Name: *Relationship to you:*

Address:
Suburb: *Postcode:*

Contact numbers: *Home / Work:* *Mobile:*

Name: D.O.B.:

3 Medical history

Do you have a history of / suffered from:

Cardiovascular:	*High blood pressure*	*Yes*	*No*	*High cholesterol*	*Yes*	*No*
	Heart attack (+/- coronary bypass / stent)	*Yes*	*No*	*Stroke or TIA*	*Yes*	*No*
Respiratory:	*Asthma*	*Yes*	*No*	*Chest & lung disease*	*Yes*	*No*
Other:	*Diabetes*	*Yes*	*No*	*Kidney problems*	*Yes*	*No*
	Cancer (any type)	*Yes*	*No*	*Epilepsy*	*Yes*	*No*
	Bowel polyps	*Yes*	*No*	*Mental illness*	*Yes*	*No*
	Depression / anxiety	*Yes*	*No*			

Do you have any allergies / adverse reactions to medicines / other substances (such as latex/food)?
Yes / No **If yes, please list:**

Are you currently taking any medications, including over the counter, vitamins or minerals?
If yes, please list:

Please list all past and current conditions:

Medical problems *Surgeries*

Date of last Pap Smear: *(if known):* *Date of last Mammogram:* *(if known):*

Date of last Male Health Check: *(if known):* *Date of last Breast Check:* *(if known):*

Social history

Tobacco: *Never* *or* *per day / week* *or date ceased smoking*

Alcohol: *Never* *or* *per day / week* *or date ceased drinking*

Height: *Weight:*

Family History	*If living, age*	*Medical conditions*	*If deceased, age*	*Cause of death*
Father				
Mother				
Brother				
Sister				
Other				

Name: *D.O.B.:*

4 Patient Consent

We require your consent to collect personal information about you. Please read this information carefully and sign where indicated below.

This medical practice participates in the National & State reminder system (e.g. PAP QLD, PAP register, Australian Childhood Register).

This medical practice collects information from you for the primary purpose of providing health care.

Your doctor in the course of a consultation may ask personal details and a full medical history so that he/she may properly assess, diagnose, treat and be proactive in your health care needs.

This means information may be used in the following way:

- administrative purposes for running the medical centre
- billing purposes including compliance with Medicare and Health Insurance Commission requirements
- disclosure to other doctors in the practice, locums and by registrars attached to the practice for the purpose of care and teaching. Please let us know if you do not want your records assessed for these purposes and we will note your chart accordingly.
- disclosure for practice accreditation which is used to improve individual and community health care and practice management. Please let us know if you do not want your records assessed for these purposes and we will note your chart accordingly.

I have read the information above and understand the reasons why my information must be collected.

I am also aware that this practice has a privacy policy on handling patient information.

I understand that I am not obligated to provide information requested for me, but failure to do so may compromise the quality of health care and treatment received.

I am aware of my right to access information collected about me, except in some circumstances where access might be legally withheld.

I understand I will be given an explanation in these circumstances.

I understand that if my information is to be used for any other purpose other than set above, my further consent will be obtained.

I consent to the handling of my information by this practice for the purpose set out above subject to any limitations on access or disclosure that I notify the practice of.

Signature: _____ *Date:* _____

OFFICE USE ONLY

Entered into B.P.: Yes / No *Date:* *Initials:* *Rechecked / validated: Yes / No* *Date:* *Initials:*