

NEW PATIENT REGISTRATION FORM

In order to provide you with the highest quality of care, we require the following information from you. This form complies with the RACGP *Standards for general practices (5th Edition)*. This means your personal health information is kept private and secure, as required by federal and state privacy laws. If you have concerns, please leave blank and discuss with your GP.

Please notify us promptly of any changes in your contact details. Accurate contact details help us identify you and your medical records, and allow us to contact you promptly about tests and results.

SECTION A: PERSONAL DETAILS

Title	Surname:	Given name:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Date of Birth:	Birth Sex:	Gender:
<input type="text"/> / <input type="text"/>	<input type="text"/>	<input type="text"/>
Medicare card number:	Medicare reference number:	Medicare card expiry date:
<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/>
Pension, Health Care Card or Veterans Affair number (if applicable)		Type of Veterans Affair card:
<input type="text"/>		<input type="text"/>
Residential Address:		Suburb:
<input type="text"/>		<input type="text"/>
Postal Address (if different)		Suburb:
<input type="text"/>		<input type="text"/>
Home number:	Mobile number:	Work number:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Email address:		
<input type="text"/>		
Marital status:		
<input type="checkbox"/> Single <input type="checkbox"/> Defacto <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> N/A (Children)		
Occupation:		Are you an Elite Athlete? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="text"/>		
Next of Kin:		
Name: <input type="text"/> Relationship to you: <input type="text"/> Phone number: <input type="text"/>		
Emergency Contact: Name: <input type="text"/> Relationship to you: <input type="text"/> Phone number: <input type="text"/>		

SECTION B: CULTURAL BACKGROUND

Knowing your cultural background can help us provide healthcare that meets your individual needs.

Are you of Aboriginal or Torres Strait Islander origin?

No Yes, Aboriginal Yes, Torres Strait Islander Yes, both Aboriginal and Torres Strait Islander

Your county of birth:

SECTION C: CONSENT

Our practice uses a reminder system to help you maintain your health. The practice may send reminders by post, email, telephone or SMS for appointments and/or procedures such as vaccinations, Pap tests and other health reviews.

Our practice also sends information to the Australian Childhood Immunisation Register and Pap Smear Register. These registers also send reminders, which can be helpful if you move.

Signature of patient or guardian:

I consent to being contacted with reminders to help me maintain my health.

YES NO

I consent to being contacted with reminders to help me maintain my health.

YES NO

Date:

SECTION D: TRANSFER OF HEALTH INFORMATION

You may have consistently consulted with a GP at another practice. The health information held by that GP may assist us with your future healthcare needs. You may wish to have a copy or a summary of your health records transferred to this practice. Please ask the receptionist for information about how this can take place.

Please advise us if your contact information for Medicare details change.

How did you hear about us?

Family/Friends Facebook Google Clem Jones Centre Other: _____