COMPREHENSIVE FAMILY HEALTHCARE

Registration Form for New Patients

We need this information to provide the best quality care. 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

Personal Details:

Title: ____ *Surname:* ______________________________ *Given names:* ________________________

Date of Birth: / / *Birth Sex:* _____ *Gender Identity:*_____ *Pronouns:*________________

Marital Status:

☐ *Single* ☐ *Married* ☐ *De facto* ☐ *Separated* ☐ *Divorced* ☐ *Widowed*

Home Address: ____

*Contact Number (Home):*_______________ *(Mobile):*________________________ *Occupation:*___________

Email address: ____

Medicare Card No.: _______________________ *IRN:* ____ *Expiry Date:* _____

Private Health insurance: ____________________ *Membership/policy No:*_____________ *Expiry Date:* _____

BUPA *Private Health Insurance Policy Number:*_____________ *19 Digit Card Number:* ___________________

Pension/Seniors/Health Card No: ________________________ *Expiry Date:* ______

Australian Student Card No: _________________ *University:* ____________________ *Expiry Date:* _______

DVA No: ________________________________

Emergency Contact Person:_________________________

Contact Number:__________________ Relationship:___________________

Next Of Kin (please provide additional contact person): ________________________________

*Contact Number:*__________________ *Relationship:*___________________

Cultural Background:

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

Are you an Aboriginal or Torres Strait Islander?

☐ *No* ☐ *Yes – Aboriginal* ☐ *Yes – Torres Strait Islander* ☐ *Yes – Aboriginal & Torres Strait Islander*

Other cultural background (eg: Mediterranean, Asian, African) : _________________________________

Country of Birth: __________________________________

PLEASE TURN OVER

Is English your first language? Yes/No If not, do you require an interpreter? Yes/No
Please specify language : ________________________

Past medical History:

Do you have or have you had a history any of the following? ☐ *Operations* ☐ *Asthma* ☐ *Diabetes*
☐ *Chronic Illness* ☐ *Hypertension* ☐ *Depression/Anxiety* ☐ *Other:*__________________________

Are you taking any prescribed medication at the moment : ☐ *Yes* ☐ *No*

If yes, please list:

Do you take any "over the counter" or complementary medication? ☐ *Yes* ☐ *No*

If yes, what?

Are you allergic to any medication? ☐ *Yes* ☐ *No* *If yes, what reaction?*

Females (over25years) Date of Last Cervical Screening Test : _________________
Females (over 40years) Date of Last Mammogram : ________________
Males and females over 50 years. Date of last bowel cancer screening test : _____________

Family History:

a. Father Alive: Yes/ No ☐ *Heart Disease* ☐ *Diabetes* ☐ *Cancer* ☐ *Mental Illness* *Other (please specify):*

b. Mother Alive: Yes/No ☐ *Heart Disease* ☐ *Diabetes* ☐ *Cancer* ☐ *Mental Illness* *Other (please specify):*

Social History:

Do you smoke? Yes/No *If yes, how many a day?* ______ *What year did you start smoking?* ______

Do you drink alcohol? ☐ *Yes* ☐ *No* If yes, what quantity per week?

How did you hear about this medical centre? ☐ *Google* ☐ *From a friend/relative* ☐ *Drive and pass*
☐ *Health Engine* ☐ *Letter in the mail*

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

I consent to being contacted with reminders to help me maintain my health: Yes/No

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

I consent to being contacted with reminders to help me maintain my health: Yes/No

I consent to being contacted by SMS/Phone Calls as needed, such as for results : *Yes/No*

Preferred method of contact: ☐ *Home Phone* ☐ *Mobile* ☐ *Mail*

Signature of patient or guardian: ____________________ ***Date:*** ______________

Please show your medicare Card /private health insurance card to receptionist. Thank you.