

New Patient's Registration Form

TITLE : Mr/Mast/Mrs/Ms/Miss/Dr/Other

First Name _____ Family Name _____

Preferred Name _____ Date of Birth ___ / ___ / _____ Sex : Male Female**ADDRESS**

Suburb/Town _____ State _____ Postcode _____

MOBILE /HOME PHONE _____ Email address _____

Marital Status(Optional) _____ Occupation _____

ETHNICITY : Please chose one : Aboriginal Torres Strait Islander Both Neither

Country of Birth _____ Ethnic Background _____

Do you speak English ? Y/ N , Preferred language _____ Do you need interpreter? Y / N

NEXT OF KIN : First Name _____ Family Name _____

Phone number _____ Relationship to Patient _____

EMERGENCY CONTACT : First Name _____ Family Name _____

Phone Number _____ Relationship to Patient _____

PARENT/GUARDIAN (If child is under 16) : First Name _____ Family Name _____

Date of Birth ___ / ___ / _____, Medicare card _____ Reference Number _____

MEDICARE NUMBER _____ Reference Number _____ Expiry Date ___/___**DO YOU HAVE CONCESSION CARD**(Health care card/Pension concession card/Commonwealth senior card/DVA card(gold/silver/orange) ? **Y / N**

If YES, please fill in the card type and number _____ Expiry Date ___/___

HOW DID YOU FIND US? Google Search Social Media Walk/Drive by Friends/Relatives /Word of Mouth Flyers Booking Apps(Healthengine...etc) Other _____**CONSENT FORM**

*I HAVE READ THE PRIVACY POLICY OF THE PRACTICE AND UNDERSTAND THE REASONS WHY MY INFORMATION MUST BE COLLECTED AND AGREE TO THAT COLLECTION

*I HAVE READ THE BILLING POLICY , UNDERSTAND AND AGREE TO THE COST OF MY TREATMENT

*I CONSENT TO THE USE MY MOBILE NUMBER FOR SMS OR EMAIL TO CONTACT ME FOR THE REMINDERS, RECALLS, HEALTH ALERTS AND/OR HEALTH NEWSLETTER

***PLEASE BOOK YOUR OWN REVIEW APPOINTMENT AFTER YOUR PATHOLOGY TEST/SCAN**

Patient Signature _____ Date _____

Parent/Guardian's Signature _____ Date _____

HEALTH INFORMATION**Current Medication**(Including complementary and over-the counter medicine(e.g.homeopathic medicine such as vitamins and minerals) _____**Allergies:** Y/N , If Yes _____**Smoking Status** : Non-smoker/ Ex-smoker(Ceased date_____) / Smoker(number_____/per day)

Do you drink alcohol? Yes/No, If Yes, how many standard drinks ___/per day

Recreational Drug use , No / Yes, If Yes, Type _____, frequency _____

Medical History: Surgery/Asthma/Diabetes/Hypertension/Chronic Illness/Others _____**Family History** (Indicate which family member _____)

Surgery/Asthma/Diabetes/Hypertension/Chronic Illness/Others _____