Woodleigh Waters Medical Centre

NEW PATIENT REGISTRATION FORM

Admin to complete	Clinical team to complete
Patient details added to file	Patient details updated in MD
Date/Initial: _____	Date/Initial: _____

The information we request assists us in providing you with the highest level of care, disclosure to others involved in your health care, administrative & billing purposes, including compliance with Medicare and Health Insurance Commission requirements. 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 any concerns, please leave blank and discuss with your GP.

Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master ☐ Other

First Name:_____ Middle Name:_____ Surname: _____

Preferred Name:_____ Date of Birth:___/___/_____ Gender: _____

Marital Status: ☐Single ☐Married ☐Defacto ☐Separated ☐Divorced ☐Widowed

Home Address:_____ Postcode: _____

Postal Address:_____ Postcode: _____
(if different to home address)

Telephone Number:_____ Work:_____ Mobile:_____

Consent to SMS reminder and recalls: ☐Yes ☐No Consent for My Health Record upload: ☐ Yes ☐ No

Medicare card number:_____ IRN:_____ Expiry:___/___/_____

Pension, HCC, or Veterans Affairs Number (if applicable): _____Expiry:___/___/_____

Next of Kin
Name:_____ Relationship to you:_____

Telephone Number:_____ Mobile Number:_____

Who can we contact in an emergency? *(if different to Next of Kin)*

Name:_____ Relationship to you:_____

Telephone Number:_____ Mobile Number:_____

Australia is a genuinely multicultural country. The following questions would help us tailor appropriate care, assist with health initiatives and encourage understanding and appreciation between people from different backgrounds.

Are you Aboriginal or Torres Strait Islander descent? ☐Aboriginal ☐Torres Strait Islander ☐Neither

Country of Birth: _____ Ethnicity**:** _____ Year of Arrival is Australia: _____

Do you require an interpreter? ☐Yes ☐No If so, what language? _____

To whom should the account be addressed if the patient is a child:

Name: _____ DOB: ___/___/_____ Phone: _____

Home Address:_____ Postcode: _____

Allergies/Adverse Reactions/Warnings:

Do you have any allergies or are you sensitive to medications or dressings? ☐Yes ☐No

Medication, Dressing or substance	Reaction (eg: rash, shortness of breath, wheeze, anaphylaxis

Smoking History

☐ Smoker ☐ Ex Smoker ☐ Never Smoked
Frequency☐ Daily ☐ Less than weekly ☐ Weekly
Number of cigarettes: ____
Year Commenced: _____
Last quit attempt:_____ ☐ Unknown

Alcohol History

Do you drink alcohol? ☐Yes ☐No ☐Never
How often do you drink alcohol?
☐ Month or less ☐ 2-4x/month
☐ 2-3x/week ☐ 4 or more/week

How many standard drinks with alcohol do you have per day?
☐1or 2 ☐3 or 4 ☐5 or 6
☐ 7to 9 ☐10 or more

How often do you have 6 or more drinks?
☐Never ☐Weekly ☐Monthly
☐Less than monthly ☐Daily

Are you concerned about your drinking?
☐Yes ☐ No ☐ Don't know

Family History: Have any member of your family been diagnosed with or suffered from… (list relationship to you):

☐ Diabetes _____
☐ Cancer_____
☐ Heart Disease_____
☐ Asthma_____
☐ Other Conditions_____

Social/Family History

Who lives at home with you?

Are you a care for someone? ☐ Yes ☐No

Is someone a care for you? ☐ Yes ☐No

Health Check dates:

Last cervical screening test date: _____
Breast check:_____
Mammogram:_____
Prostate (PSA) check:_____
Bone Mineral Density (BMD) Scan:_____

Medication List (including over-the-counter)

Name	Reason

Immunisations- Please tick routine immunisations received

☐Birth ☐6 weeks/2months ☐ 4 months
☐6 months ☐12 months ☐ 18 months
☐4 years ☐Year 7 school Vaccines
☐Year 10 school vaccines
Others: _____

Privacy Consent

I have read the information above and understand the reasons 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 obliged to provide any information requested of me, but failure to do so might compromise the quality of health care and treatment I receive.

I am aware of my right to access information collected about me, except in circumstance where access might be legitimately 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 out above, my further consent will be obtained.

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

Full Name:	**Date:**
Signature of Patient or Parent/Guardian:	