Patient Registration Form

We need this information to provide the best quality care. This form complies with the RACGP Standards for general practices. 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:

Surname:	First Name:
Middle Initial:	Preferred Name:
Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Other:	
Occupation:	DOB:
Sex:	Gender:
Marital Status:	Pronouns:

Home Address:
Postal Address:

Mobile No:	Home No:
Work No:	Email:

Medicare No: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ Expiry: Individual Reference No: ___
Health Care/Pension Card: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ Expiry:
DVA Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ Expiry:

Next of Kin:	**Emergency Contact:**
Name:	Name:
Relationship to you:	Relationship to you:
Contact No:	Contact No:

Would you like to have appointment reminders sent via SMS? ☐ Yes ☐ No

We provide our patients with preventative care and early case detection reminders e.g: - immunisations, annual health checks, skin checks and pap smears.
Do you consent to being contacted with reminders to help maintain your health? ☐ Yes ☐ No

We also send information to the Australian Immunisation Register and the National Cancer Screening Register. These Registers may also send reminders.
Do you consent to your information being sent to external Registers? ☐ Yes ☐ No

Do you have an advance health directive for end of life care? ☐ Yes ☐ No

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

Do you identify as someone from a culturally and/or linguistically diverse background?

☐ Yes ☐ No Country of birth: _____

Is English your first language? ☐ Yes ☐ No

If not, do you require an interpreter? Please specify language: _____

Medical Information:

Do you have any allergies or intolerances? * *Include medications, medical dressings, food etc.**

☐ Yes ☐ No

If yes, please list and describe your reaction:

Do you have a history of:			Does anyone in your family have a history of:		
Asthma:	☐ Yes	☐ No	Asthma:	☐ Yes	☐ No
Diabetes:	☐ Yes	☐ No	Diabetes:	☐ Yes	☐ No
Heart Disease:	☐ Yes	☐ No	Heart Disease:	☐ Yes	☐ No
Mental Illness:	☐ Yes	☐ No	Mental Illness:	☐ Yes	☐ No
Cancer:	☐ Yes	☐ No	Cancer:	☐ Yes	☐ No
Gestational Diabetes:	☐ Yes	☐ No	Kidney Disease:	☐ Yes	☐ No

Please detail any surgeries or procedures you have had:

Please list any regular medications you take: **including over the counter medications, vitamins etc.**

Signature of Patient: **Date:**

Signature of Carer/Guardian: ***if applicable**** **Date:**

Details Entered: