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New Patient Registration Form

All fields marked with an asterisk (*) are required.

Personal Details

Title*

First Name*

Middle Name

Last Name*

Preferred Name

Gender*

Date of Birth*

Occupation

Street address*

Suburb*

Postcode*

Mobile phone*

Home Phone

Email*

Health Initiatives

In order to assist us with health initiatives and tailor care. If you identify as Aboriginal or Torres Strait Islander you are eligible to be bulk billed.

Are you*:
☐ Aboriginal

☐ Torres Strait Islander

☐ Not Aboriginal or Torres Strait Islander

Nationality*

Medical Information

Medicare Card

Number | Position on Card | Expiry Date

DVA Card

Number | Expiry Date | Type

Pension/Health Care Card

Number | Reference | Expiry Date

Emergency Contact Information

We collect this information in case of emergency

Next of Kin

First Name* Last Name* Relationship*

Contact number* Address*

Emergency Contact

☐ Same as next of kin

First Name* Last Name* Relationship*

Contact number* Address*

Social Activities

Do you smoke*

☐ Yes How many per day

☐ No

Do you drink alcohol*

☐ Yes How many per day How many days per week

☐ No

Your Health History

Do you have any allergies or are sensitive to drugs or dressings*

☐ Yes Details

☐ No

Do you have or had a history of?

Operations*

☐ Yes Details and approximate dates

☐ No

Asthma*

☐ Yes Date of diagnosis

☐ No

Diabetes*

☐ Yes Date of diagnosis

☐ No

Hypertension*

☐ Yes Date of diagnosis

☐ No

Chronic Illness*

☐ Yes Details (including date of diagnosis)

☐ No

Other*

☐ Yes Details (including date of diagnosis)

☐ No

Have you had a cervical screen*

☐ Yes Date of most recent

☐ No

Have you had a mammogram*

☐ Yes Date of most recent

☐ No

Have you had a prostrate check*

☐ Yes Date of most recent

☐ No

Current Medications

Name* Dosage* Use*

Name* Dosage* Use*

Family History

Please list any significant family history (including your parents, children, brothers, sisters, grandparents, aunts, uncles, nieces, nephews and grandchildren) of:

☐ Diabetes ☐ Asthma ☐ High Blood Pressure

☐ Heart Disease ☐ Stroke ☐ Emphysema

☐ Mental Illness ☐ Cancer ☐ Other Significant

If yes, provide details

Interpreter

Do you need an Interpreter?*

☐ Yes Language

☐ No

Consent

Our Practice uses a reminder system to help you maintain your health. I consent to receive SMS reminders, messages and emails*

☐ I agree

I give my consent to share my medical records between health professionals*

☐ Yes

☐ No

I give consent for family members to pick up my scripts, pathology requests and/or referral letters*

☐ Yes

☐ No

I consent to the Doctors and Practice sending information to the Australian Immunisation Register (AIR) and access the AIR on my behalf *

☐ I agree

Where eligible, I give my consent to bulk bill medicare for my consultation*

☐ I agree

Fees policy

We are a Private Billing Practice. It is the policy of the Practice that payment for consultation is made at the time of your appointment. We will inform you of the fee to be charged for your consultation.

By proceeding with your appointment, you agree and consent to payment of fees, including bulk billing Medicare, if eligible.

Please visit our website for further details.

Cancellation

We require 3 hours notice if you wish to change or cancel your appointment. A $20 cancellation fee, per 15 minute booked appointment time will be charged for non-attendance or where 3 hours notice to the practice is not provided.

We understand that sometimes you may be unable to keep an appointment because of sudden illness or an unexpected personal emergency. If this happens to you, please contact the practice as soon as possible to explain the situation.

At our discretion we may refuse to accept further appointments for patients who do not respect this policy by continuing to fail to attend appointments or fail to provide sufficient notice.

I acknowledge that I have read and understand this Fees Policy. *

☐ I agree

I further understand that I will incur fees in the event I fail to give the required amount of notice before my scheduled appointment or if I fail to show up for my scheduled appointment. Any fees incurred are my responsibility to pay, such fee shall be paid at my next appointment or I give consent for this fee to be paid through an online payment system.*

☐ I agree

Patient Code of Conduct

I agree and acknowledge:

- I will inform the doctor if I am receiving treatment from another health professional.
- I will disclose my medical history including medications to my doctor.
- I have read and understood the cancellation policy and will notify reception in accordance with this policy when I cannot keep an appointment.

- I will pay for any service and products received as advised by my doctor or the practice.

- I will conduct myself in a manner that does not interfere or threaten the rights of other patients or staff.

Do you agree to these terms?*

☐ I agree

Transfer of Medical Records

Would you like to transfer your medical records to our practice?

☐ Yes

☐ No

Doctors name and name of medical centre

Contact details

Privacy and Terms

We are committed to protecting the confidentiality of your personal information and health records. In submitting this form, you;

1. acknowledge that we, and our service providers, will collect your personal and health information to enable us to provide you with our health services and any related communications (for example, to manage your appointment bookings); and
2. consent to our handling of your personal information in accordance with our Privacy Policy (you can access our Privacy Policy on our website, or by asking us for a copy).

Do you agree to these terms?*

☐ I agree

Signature