Patient 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: Mr / Mrs / Ms / Mast / Miss / Dr / Prof	Gender:	Date of Birth: / /
First Name:		Middle Name:
Surname:		Preferred Name:

Medicare Card No:											Medicare Ref No:		Medicare Expiry date: / /

Pension/ Health Card/ Veterans Affairs No. if any:	Type of Veterans Affairs card:	Expiry date:	/ /

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

Home Address:	Post Code:

Phone: Home:		Work:	Mobile:
Email:			Occupation:
Next of Kin: Name:		Relationship:	Contact No:
Emergency Contact: Name:		Relationship:	Contact No:

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

Are you Aboriginal or Torres Strait Islander (ATSI)?

No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, Both Aboriginal and Torres Strait Islander ☐

Country of Birth:	Other cultural background (eg Mediterranean, Asian, African)	Year of arrival in Australia:
Languages Spoken:		Interpreter required: Yes ☐ No ☐ Please specify Language:

Allergies and medicines.

List allergies and intolerances to medications	Describe your reaction

List regular medications and doses, and complementary medicines and doses

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 Childhood 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 ☐

Transfer of health information

You may have consistently consulted with a GP at another practice. The health information held by that GP may assist us with your future healthcare needs. You may wish to have a copy or a summary of your health records transferred to this practice. Please ask the receptionist for information about how this can take place

Please advise us if your contact information or Medicare details change.

Patients Signature: ..... Date: ...../...../.....

Office Use Only: **Photo ID Checked:** **Sighted By:**