Whitsunday Family Practice

New Patient Registration

Personal Information

☐MR ☐MRS ☐MISS ☐MS ☐MASTER ☐DR ☐OTHER:

FAMILY NAME: _____ AS PER MEDICARE

FIRST NAME: _____

MIDDLE NAME: _____

DATE OF BIRTH: _____ SEX: ☐MALE ☐FEMALE

ETHNICITY: ☐ABORIGINAL ☐TORRES STRAIT ISLANDER ☐OTHER: _____

OCCUPATION: _____

At work are you exposed to any of the following? ☐Asbestos ☐Dust ☐Radiation ☐Animals

HOME ADDRESS: _____SUBURB: _____POSTCODE:_____

POSTAL ADDRESS: _____SUBURB: _____POSTCODE:_____

HOME PHONE: _____WORK PHONE: _____MOBILE PHONE: _____

Which would you prefer us to contact you on? ☐Home ☐Work ☐Mobile

EMAIL ADDRESS: _____

Billing Information

MEDICARE CARD NUMBER: ___/___/___/___/ ___/___/___/___/___/ ___/ Ref:(no next to name) ___/ EXPIRY:___/___ ___/___/___/___/

CONCESSION CARD NUMBER:___/___/___/ ___/___/___/ ___/___/___/___/ EXPIRY:___/___/ ___/___/ ___/___/___/___/

Type of Concession Card? ☐Pension ☐Health Care

DVA CARD NUMBER: _____

Type of DVA? ☐Gold ☐White - Condition_____

PRIVATE HEALTH FUND NAME: _____

If the patient is under 18 years of age and will not be responsible for payment, please complete the following:

☐Mother ☐Father ☐Guardian

FAMILY NAME: _____ FIRST NAME: _____

PHONE NUMBER: _____ DATE OF BIRTH: _____

MEDICARE CARD NUMBER: ___/___/___/___/ ___/___/___/___/___/ ___/ Ref: ___/ EXPIRY:___/___ ___/___/___/___/

ETHNICITY: ☐ABORIGINAL ☐TORRES STRAIT ISLANDER ☐OTHER: _____

Next of Kin Information

Please tick if above Parent/Guardian details are the same☐

NAME: _____

RELATIONSHIP TO PATIENT: _____

PHONE: _____

Emergency Contact Information

Please tick if NEXT OF KIN details are the same☐

NAME: _____

RELATIONSHIP TO PATIENT: _____

PHONE: _____

Medical Information -PLEASE COMPLETE ALL SECTIONS

BRIEF Reason for today's visit:

CURRENT MEDICATIONS OR **No Medication☐**

_____

_____

_____

ALLERGIES AND REACTIONS OR **Nil Known☐**

_____

_____

_____

MEDICAL HISTORY OR **No Significant History☐**

_____

_____

_____

SURGERY/HOSPITAL ADMISSIONS OR **Nil☐**

_____

_____

_____

If unsure please ask to see Practice Nurse **HEIGHT (CM):** **WEIGHT (KG):** **WAIST (CM):**

IMMUNISATIONS: If you have evidence of Immunisations please provide us a copy for your records.

☐Childhood Vaccines upto date ☐Tetanus_____mth_____year ☐Flu_____mth_____year **☐Unknown**

WOMEN'S HEALTH:

When was your last Pap Smear_____ **OR** ☐Unknown Last Mammogram_____ **OR ☐Unknown**

Was the Pap Smear Result ☐Negative ☐Other_____

Would you like a reminder when your next Pap Smear is due? ☐Yes Please ☐No Thank You

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MEN'S HEALTH: over 40 years of age

When was your last Prostate Check _____year **OR** ☐Unknown

LIFESTYLE HEALTH

Smoking: ☐Never ☐Current Smoker_____per day ☐Former Smoker_____date quit

Alcohol: ☐Never ☐Current Drinker_____per day OR _____per week Past Intake ☐Occasional ☐Moderate ☐Heavy

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FAMILY HISTORY

Mother **☐Nil Significant**

☐Alive ☐Deceased_____Age at Death ☐Diabetes ☐Heart Disease ☐Hypertension ☐Stroke ☐Asthma ☐Cancer_____

Father **☐Nil Significant**

☐Alive ☐Deceased_____Age at Death ☐Diabetes ☐Heart Disease ☐Hypertension ☐Stroke ☐Asthma ☐Cancer_____

CONSENT

In accordance with the *Privacy Act (1988),* all information collected in this practice is treated as "sensitive information". To protect your privacy, this practice operates in accordance with the Act.

- We use the information you provide to manage your health care. You can assist in maintaining the accuracy of your information by advising the practice of changes of address, phone number etc.
- Selected information may be disclosed to various other health services involved in supporting your health care management
- I agree that it remains my responsibility at all times to contact the practice regarding tests that have been ordered by my Health Practitioner.

☐ I consent for Whitsunday Family Practice to communicating via SMS text message for Reminders, Recalls and Results.

☐ I wish for Whitsunday Family Practice to upload my health summary to MyHealthRecord

Patient/Guardian Full Name: _____ Date:_____

Patient/Guardian Signature: _____