



New Patient Registration Form

The Doctors and Staff at this clinic are committed to whole patient care. This includes preventative and ongoing care. To assist us maintain your wellbeing we ask you to complete this form. All information collected about you will remain confidential.

Title: _____ First Name: _____ Family Name: _____ Date of Birth: __ / __ / __

Gender: _____ Medicare Number: _____ Reference Number: ____ Exp: ____ / ____

Please Circle **Pension/Health Care Card Number:** _____ Exp: ____ / ____ / ____

DVA (Veteran Affairs) Gold/White: _____ Exp: _____

Address: _____ Suburb: _____ Postcode: _____

Home Phone: _____ Mobile: _____ Business No: _____

E-mail Address: _____

Next of Kin: _____ Gender: _____ Relationship: _____ Phone: _____

Same as Next of kin

Emergency Contact: _____ Gender: _____ Relationship: _____ Phone: _____

Please circle Are you Aboriginal/Torres Strait Islander **Yes/No**

Country of Birth: _____ Year of Arrival: _____ Self-identified ethnicity: _____

Please list current Medications: _____ Not taking any medications

Please list any Allergies: _____ **Reaction:** _____

Please list any operations/previous illness: _____ No significant medical history

Do you currently smoke? YES/NO
How many per day? _____

Are you an ex smoker? YES/NO
Quit Date _____

Do you drink alcohol? YES/NO
How often? _____

Have you ever had or have any of the conditions below? If Yes please circle

Diabetes Kidney disease Asthma Bowel Cancer Breast Cancer High blood Pressure Heart Problems Epilepsy
Other: _____

Is there a family history of any of these conditions? If yes please state relationship

Diabetes Kidney disease Asthma Bowel Cancer Breast Cancer High blood Pressure Heart Problems Epilepsy
Relationship to you (Mother, Father, Grandparent): _____

Who do you live with? _____ How many children do you have? ____ Marital Status _____

Occupation: _____ How did you hear about us? _____

Are you planning to attend Ballarto medical centre for ongoing care. **DO NOT tick if you are visiting.**

PRIVACY

We must obtain your consent for messages to be left on your telephone or mobile answering or message bank regarding matters involving your health. Do you agree? **YES/ NO**

REMINDER SYSTEM

Our practice provides our patients with preventative care and early case detection reminders e.g.: immunisations, annual health checks, skin checks and pap smears. **Do you agree for reminders to be sent to you by mail or SMS YES / NO**

This clinic participates in SMS reminders for some appointments and health initiative reminders. Please circle if you DO NOT wish to be part **NO**

CONSENT

I Consent to the collection, use and handling of my information by the practice for the purposes set out above.
For further information please refer to our collection and use statement displayed at reception or ask for a copy of our Privacy Policy.

Name: _____ **Signature:** _____ **Date:** _____

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