Clyde North Medical Centre | Selandra Rise

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 Clyde North 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 aove.
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:**_____________

OFFICE USE ONLY. Entered Pracsoft .... Entered MD.................