HEALTH 104
personalised health & wellness centre

New Patient Registration Form

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

Personal Details

Title ☐ Miss ☐ Ms ☐Mrs ☐Mr ☐ Dr ☐ Other

First name* _____

Last name* _____

Preferred name _____

Gender* ☐ Female ☐ Male ☐ Other

Date of birth* _____

Occupation _____

Street address* _____

_____

Suburb* _____

Postcode* _____

Mobile phone* _____

Home phone _____

Email address _____

Health Initiatives

In order to assist us with health initiatives and tailor care

Do you identify as Aboriginal or Torres Strait Islander?* ☐ Yes ☐ No

What is your country of birth? _____

Medical Information

MEDICARE CARD

Do you have a Medicare card?* ☐Yes ☐No

Medicare card number: _____

Medicare card ref number: _____

Expiry date: _____

DVA CARD

Do you have a DVA card? ☐Yes ☐No

Card number: _____

Expiry date: _____

PENSION/HEALTH CARE CARD

Do you have a Pension/Health Care card? ☐Yes ☐No

Card Number: _____

Emergency Contact Information

We collect this information in case of an emergency

NEXT OF KIN

First name* _____

Last name* _____

Relationship* _____

Contact number* _____

EMERGENCY CONTACT

Same as Next of Kin* ☐Yes

First name _____

Last name _____

Relationship _____

Contact number _____

Your Health History

Do you have any allergies or are you sensitive to drugs or dressings* ☐Yes ☐No

DO YOU HAVE OR HAD A HISTORY OF?

Operations* ☐Yes ☐No

Asthma* ☐Yes ☐No

Diabetes* ☐Yes ☐No

Hypertension* ☐Yes ☐No

Chronic illness* ☐Yes ☐No

Other*_____

_____

Immunisations

Have you had the following immunisations?

Tetanus booster ☐Yes ☐No ☐Not Sure If yes, date of when immunised _____

Hepatitis B ☐Yes ☐No ☐Not Sure If yes, date of when immunised _____

Hepatitis A ☐Yes ☐No ☐Not Sure If yes, date of when immunised _____

Influenza ☐Yes ☐No ☐Not Sure If yes, date of when immunised _____

Pneumococcal ☐Yes ☐No ☐Not Sure If yes, date of when immunised _____

Polio ☐Yes ☐No ☐Not Sure If yes, date of when immunised _____

Social Activities

Do you smoke?* ☐Yes ☐No

Do you drink alcohol?* ☐Yes ☐No

What was the main reason you decided to book at our practice?

Please circle:

Family/friend recommendation, Saw on Street, Google, Social media (e.g. Facebook), HotDoc , Referral from health professional, Other _____

Communication

I consent to receive SMS reminders, messages and emails* ☐Yes ☐No

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 the terms?* ☐ Yes ☐ No

Signature * _____