YOUR HEALTH PLACE MEDICAL CENTRE

REGISTRATION FORM

TITLE MR/ MRS/ DR/ MS/ MISS/ MASTER (Please circle)

SURNAME _____

FIRST NAME _____

PREFERRED NAME _____ DATE OF BIRTH _____

ADDRESS _____ SUBURB _____

HOME PH: _____ WORK PH: _____ Mobile: _____

EMAIL: _____

OCCUPATION _____

COUNTRY OF BIRTH _____ MARITAL STATUS _____

PREFERRED LANGUAGE _____ DO YOU NEED AN INTERPRETER? YES / NO

ARE YOU ABORIGINAL OR TORRES STRAIT ISLANDER ORIGIN? YES / NO/ YES – BOTH

MEDICARE NUMBER __ __ __ __ __ __ __ __ __ __ EXPIRY __ __/ __ __

REFERENCE NO. ON THE CARD ___ (This number is displayed on the left side of the name)

DO YOU HAVE A HEALTHCARE CARD OR CONCESSION CARD: YES / NO

IF YES, PLEASE CIRCLE WHICH ONE: HEALTHCARE / AGE PENSION / SOLE PARENT / DISABILITY

CARD No: _____ EXPIRY DATE: _____

EMERGENCY CONTACT

TITLE: MR / MRS / DR / MS / MISS (Please circle)

NAME _____

RELATIONSHIP _____

CONTACT PHONE _____

Is your Emergency Contact the same as your Next of Kin? YES NO (Please circle one). If NO, please give their details:

NAME _____

RELATIONSHIP _____ PHONE _____

PRIVACY STATEMENT By signing below, you (as patient/parent/guardian) are consenting to your personal information, to be used or disclosed for the following purposes:

- The diagnosis and treatment of any health condition, including the communication of relevant information only to practice staff
- Follow up notices for treatment and preventative healthcare
- For legal related disclosure as required by a court of law
- For disease notification as required by law
- For use when seeking treatment by other doctors in the practice or when referred to other health practitioners
- For national / state reminder system registry such as pap smear, immunization, etc.
- I give my permission for my personal health information to be collected, used and disclosed as above. I understand that only the relevant personal health information will be provided to allow the above actions to be undertaken and I am free to alter or restrict my consent at any time by notifying the practice in writing.

- I understand that this is a teaching practice and often a third party mayl be present in my consultation, I give my consent to have this party present. In circumstances where I do not agree, I will indicate this prior to or at the beginning of my consultation.

PATIENT / PARENT / GUARDIAN SIGNATURE_____ DATE _____ **PLEASE TURN OVER**

PERSONAL HEALTH SUMMARY

FAMILY HISTORY

	ILLNESSES AND PROBLEMS	AGE	IF DECEASED, AGE AT DEATH
FATHER			
MOTHER			
OTHERS			

DO YOU EVER SUFFER / HAVE YOU EVER SUFFERED FROM ANY OF THE FOLLOWING

- Asthma
- Hay fever
- Eczema
- Skin problems
- Heart problems
- High blood pressure
- High cholesterol
- Stroke
- Menopausal problems
- Arthritis
- Diabetes
- Indigestion / reflux
- Stomach ulcers
- Cancer (if yes, which one?)_____
- Constipation
- Kidney problems
- Bladder problems
- Eye problems
- Ear problems
- Sinus problems
- Thyroid problems
- Depression / anxiety/ other psychological condition
- Neurological condition (e.g. epilepsy/MS/other)

HAVE YOU HAD ANY OPERATIONS IN THE PAST? PLEASE LIST OPERATION & YEAR

_____

_____

_____

DO YOU HAVE ANY ALLERGIES? IF NO ALLERGIES, PLEASE WRITE "NO", OR IF YOU HAVE ALLERGIES, PLEASE LIST

_____

_____

PLEASE LIST ANY MEDICATIONS WHICH YOU ARE CURRENTLY TAKING, INCLUDING HERBS, VITAMINS AND OVER THE COUNTER PREPARATIONS (ANYTHING YOU CAN BUY WITHOUT DOCTOR'S PRESCRIPTION).

_____

_____

_____

DO YOU SMOKE?	YES / NO	IF YES, HOW MANY PER DAY? _____SINCE_____
HAVE YOU EVER SMOKED?	YES / NO	IF YES, WHEN DID YOU GIVE UP?
DO YOU DRINK ALCOHOL?	YES / NO	IF YES, HOW MUCH, HOW OFTEN? _____
DO YOU EXERCISE REGULARLY?	YES / NO	**DO YOU SLEEP WELL?** YES / NO

PATIENT / PARENT / GUARDIAN SIGNATURE _____ DATE _____

How did you find out about Your Health Place Medical Centre? (Please circle as many as apply)

Advertisement Google/Online Walking/Driving Past Friend or Family