Evans Road
Medical Centre

NEW PATIENT REGISTRATION FORM

We are committed to providing our patients with the best care. To do this, it is essential that your personal information is up to date and accurate. All information collected will remain confidential.

Title: _______ Given Name: ______________________________ Middle Name: _____________________

Surname: ___________________________________ Date of Birth: _____/______/_________

Gender at birth: Female / Male Preferred Name: _____________________________

Medicare Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ Ref: ____ Exp: ____/___/______

Pension/ Health Care Card Number: ___________________________________ Exp: ____/___/______

DVA (Veterans Affairs): Gold/White: _____________________________________ Exp: ____/___/______

Private Health Insurance (please circle): **BUPA NIB MEDIBANK ALLIANZ CBHS**

Membership Number: ______________________________ Ref: _____ Exp: ____/____/______

Address: ____Postcode: ________

Suburb: ________________________________ Mobile: _________________________

Home Phone: ___________________________ Work Phone: ______________________

Email Address: ____

1) Next of Kin Name: _______________________________ Relationship: _________ Phone: ____________

2) Emergency Contact Name: _______________________ Relationship: _________ Phone: ____________

Please Circle: Are you Aboriginal/Torres Strait Islander **YES / NO**

Country of Birth: _______________________ Self-identified Ethnicity: _______________________

HEALTH HISTORY

Allergies: YES / NO **If yes, please list:** ____

Please list current medications: ____

Smoking status (circle) Nonsmoker / Ex-Smoker /Smoker If yes, how many per day? ___________

Do you drink alcohol? **YES / NO** How often: ________________________________

Have you ever had or have any of the conditions below? If yes, please circle.

Asthma/ Diabetes / Kidney Disease/ Cancer/ High Blood Pressure/ Heart Problems/ Stroke/ Epilepsy

Other: ____

- PRIVACY: We obtain your consent for messages to be left on your telephone answering or voicemail regarding your health. **Do you agree: YES / NO**
- REMINDER SYSTEM: Our practice provides our patients with preventive care and early detection reminders e.g.: immunisations, pap smears, health checks. Do you wish to receive SMS reminders for appointments and health initiative reminders? **YES / NO**

CONSENT: I consent to the collection, use and handling of my information by the practice for the purposes set out above.

Patient's Signature: ______________________ Date: _____/______/_____