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 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 (Veterans Affairs) Gold/White: _____ Exp: _____

Address: _____ **Suburb:** _____ **Postcode:** _____

Home Phone: _____ **Mobile:** _____ **Work Number:** _____

Email Address: _____

Next of Kin: _____ **Relationship:** _____ **Phone:** _____

Emergency Contact: _____ **Relationship:** _____ **Phone:** _____

Please circle: Are you Aboriginal/Torres Strait Islander YES / NO

Country of Birth: _____ **Self-identified ethnicity:** _____

HEALTH HISTORY:

Allergies: YES / NO List if yes: _____

Please list current medications: _____

Smoking Status: (please circle) Non Smoker / Ex Smoker / Smoker If smoker, 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 Bowel Cancer Breast Cancer High Blood Pressure Heart Problems Stroke Epilepsy

Other: _____

PRIVACY
We 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 eg: immunisations, annual health checks and pap smears. Do you wish to participate in SMS reminders for some 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.

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