SALISBURY DOCTORS NEW PATIENT REGISTRATION FORM

PATIENT'S DETAILS

Title: Mr / Mrs / Ms / Miss / Mast / Dr / Prof Gender: Male / Female

First Name: _____ Surname: _____ Date of Birth: ___/___/_____

Are you: ☐ Non-Indigenous ☐ Aboriginal ☐ Torres Strait Islander ☐ Australian ☐ Other _____

Medicare Card Number: _____ Individual Number: ___ Expiry: _____

☐Pension ☐Healthcare ☐Seniors Card Number: _____ Expiry: _____

Marital Status: ☐ Single ☐ Married ☐ De facto ☐ Separated ☐ Divorced ☐ Widowed

Address:_____

Suburb: _____ State: _____ Post Code: _____

Mobile Number: _____ Home Phone Number: _____

Email: _____ Occupation: _____

Height: _____ cm Weight: _____ kg (Please ask nurse/doctor if unsure)

Emergency contact: First Name: _____ Surname: _____

Relation: _____ Phone: _____

Next of Kin contact: First Name: _____ Surname: _____

Relation: _____ Phone: _____

MEDICAL INFORMATION

List known allergies: _____

Smoking History: ☐ Smoker ☐ Ex-Smoker ☐ Never Smoked

Cigarettes per Day_____ Year Started _____ Year Quit _____

Drinking History: ☐ Non-drinker ☐ Drinker

Days per Week_____ Standard Drinks per Day_____

List past health history:
☐ Coronary Heart Disease ☐ Stroke ☐ Lung Cancer ☐ Breast Cancer ☐ Any other Cancer
☐ Type 2 Diabetes ☐Chronic Kidney Disease ☐ Epilepsy ☐ Arthritis ☐ Osteoporosis ☐ Asthma
☐ Depression & Anxiety ☐ Chronic Pains ☐ Chronic Obstructive Pulmonary Disease (COPD)
Since when _____

Do you have any other significant medical conditions? If so, please list below with year of diagnosis:

_____

PRIVACY AND PATIENT CONSENT

As a patient of our medical practice, we require you to provide us with your personal details and a full medical history, so that we may properly assess, diagnose, treat and be proactive in your health care needs. We aim to protect the privacy of your health information.

I have read the information above and understand the reasons why my information must be collected.

I understand that I am not obliged to provide any information requested of me, but failure to do so may compromise the quality of health care and treatment given to me.

I am aware of my rights to access the information collected about me, except in some circumstances where access may be legitimately withheld. I will be given an explanation in these circumstances.

I consent to the handling of my information by the practice for the purpose set out above, subject to any limitations on access or disclosure of which I notify this practice.

Signed: …….. Date: ...../……../20….

Patient Name/Parent or Guardian Name: …….....