SALISBURY DOCTORS

Shop 6/660 Toohey Rd, Salisbury, QLD 4107
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New Patient Registration Form

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

First Name: ____________________ **Surname:** ____________________ **Date of Birth:** ____/ ____/____

Do you identify yourself as: 1. Non-Indigenous 2. Aboriginal or 3. Torres Strait Islander? _________________

Medicare Card Number:_________________________ **Individual Number:**_______**Expiry:**__________________

Pension / Healthcare Card Number:______________________________________**Expiry:**____________________

Marital Status: Single Married De facto Separated Divorced Widowed

Address: ____

Suburb: ____________________________________ **State:** __________________ **Post Code:** ___________

Mobile Number: _____________________________ **Work Phone Number:** ____________________________

Home Phone Number: ________________________ **Occupation:** ____

Height: ________ **CM** **Weight:** _________ **KG** **(Please ask nurse/doctor if unsure)**

List known allergies: ____

Smoking History (Please Circle): **Smoker** **Ex-Smoker** **Never Smoked**

Cigarettes per Day________ **Year Started** ________ **Year Quit** ________

Drinking History (Please Circle): **Non-drinker** **Drinker**

Days per Week________ **Standard Drinks per Day**_______

Do you suffer from any of the following?

	Yes	Year Diagnosed	No		Yes	Year Diagnosed	No
Coronary Heart Disease				Epilepsy			
Stroke				Arthritis			
Lung Cancer				Osteoporosis			
Breast Cancer				Asthma			
Any other Cancer				Depression & Anxiety			
Type 2 Diabetes				Chronic Pains			
Chronic Kidney Disease				Chronic Obstructive Pulmonary Disease (COPD)			

If you are having any of the above conditions, have you done annual health assessment and Chronic disease management plan? If yes, when was it done last time?

___

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

___

___

Emergency Contact Details		Next of Kin (if different from Emergency contact)	
First Name:	Surname:	First Name:	Surname:
Relation:		Relation:	
Phone Number:		Phone Number:	

Please read this consent form carefully, and sign where indicated below.

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: ………………………………………........