HealthSure MEDICAL CENTRES

Registration Form
For new patients

We need this information to provide the best quality care. This form complies with the RACGP *standards for general practices (5th edition).* This means your personal health information is kept private and secure, as required by federal and state privacy laws. If you have concerns, please leave blank and discuss with your GP.
Please notify us promptly of any changes in your contact details. Accurate contact details help us identify you and your medical records, and allow us to contact you promptly about test and results.

Please print letters.
Use black or blue pen.
Place ☒ in all applicable boxes.

Section A: **Personal Details**

Title **Surname** **Given names**

Date of birth (dd/mm/yy/) **Gender** **Marital status**
Single ☐ Married ☐ Defacto ☐ Seperated ☐ Divorced ☐ Widowed ☐

Medicare card number **Medicare reference number** **Medicare card expiry date**

Pension, Health Care Card, or Veterans Affairs number (if applicable) **Types of Veterans Affairs card** **Expiry Date**

Occupation

Home address Postcode

Postal address Postcode

Telephone number Work number Mobile number

Email

Next of Kin
Name

Telephone number Work number Mobile number

Who can we contact in an emergency?
Name

Telephone number Work number Mobile number

Do you have an advance care directive for end of life card? Yes ☐ No ☐ For more information talk to your GP.

Alcohol Intake? ☐ Yes, How Many Per Week? ☐ ☐ No

Smoker? ☐ Yes, How many per day? ☐ ☐ Non Smoker ☐ Ex Smoker? Year you stopped: ☐

Section B: **Personal Details**

Knowing your cultural background can help us provide healthcare that meets your individual needs.

Are you of Aboriginal or Torres Strait Islander origin?

No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, both Aboriginal and Torres Strait Islander ☐

Other cultural background (eg Mediterranean, Asian, African)	Country of Birth

Is English your first language? Yes ☐ No ☐

If not, do you require an interpreter? Yes ☐ No ☐

Please specify language

Section C: **Allergies and medicines**

List allergies and intolerances to medications	**Describe your reaction**

List regular medications and doses, and complimentary medicines and doses

Section D: **Consent**

Our practice uses a reminder system to help you maintain your health. The practice sends reminders by post, email, telephone or SMS for procedures such as vaccinations, Pap tests and other health reviews.	**I consent to being contacted with reminders to help me maintain my health**	Yes ☐ No ☐
Our practice also sends information to the Australian Childhood Immunisation Register and Pap Smear Register. These registers also send reminders, which can be helpful if you move..	**I consent to being contacted with reminders to help me maintain my health**	Yes ☐ No ☐
To assist other medical practitioners or institutions who may treat me in the future. This may include a requirement to forward relevant information, for example, previous test results.	**I consent**	Yes ☐ No ☐
To inform my next of kin or other nominated person, regarding an emergency, or to obtain consent for treatment when I am unable to provide such consent.	**I consent**	Yes ☐ No ☐
To assist us in the requirements for accreditation and audits of our facility by accreditation authorities engaged to assess the surgery's processes and activities.	**I consent**	Yes ☐ No ☐

Signature of patient or guardian

Date

Section E: **Transfer of health information**

You may have consistently consulted with a GP at another practice. The health information held by that GP may assist us with your future healthcare needs. You may wish to have a copy or a summary of your health records transferred to this practice. Please ask the receptionist for information about how this can take place.

Please advise us if your contact information or Medicare details change.

OFFICE USE:

Copied and sighted 3 forms of patient I.D (one must be photo I.D.)
Please list 1._____ 2._____ 3._____