MEDICALS REGISTRATION FORM

We need this information to provide the best quality care. This form complies with the RACGP Standards for medical 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 the Dr. Visit privacy policy on website

Patient Details

Mr/Mrs/Miss/Ms/Mstr _____ Sex Male / Female / Other _____

First Name _____ Surname _____

Aboriginal or Torres Strait Islander Yes / No Ethnicity _____

Date of Birth _____ Marital Status Single / Married /Divorced/De facto

Medicare Number _____ Reference Expiry

Preferred prounoun _____ _____

_____

Street Number & Name _____

Suburb Postcode _____

Home Phone _____ Mobile _____

Work Phone _____ Email Address _____

Occupation Country of Birth _____

Emergency Contact

Emergency Contact Person _____ Phone (W/H) _____

Relationship _____ Mobile _____

Next of Kin Contact Person _____ Phone (W/H) _____

Relationship _____ Mobile _____

IF A COAL BOARD MEDICAL – YOUR LUNGSCREEN NUMBER____(GO TO WWW.LUNGSCREEN.COM TO GET ONE

IMPORTANT!!! PLEASE READ

The practice preferred method of contact is SMS but any other methods of contact you have provided us (phone, email, letter) may be used when needed. Do not give us any contact we can't use for you for communication with you for any reason including health promotions.

To opt off all SMS communications, you must inform the receptionist today to OPT OFF ☐

For SMS messages it is understood that my details are utilised by the Hotdoc App ,Automed and Best Practice management program and their Best Health app for the basis of these practice communications (e.g. appt reminders, checkups due, Drs messages to you, relevant health info) in accordance with the Privacy Act.

I further confirm that my mobile phone is for my private use and is locked and has a unique password for my apps known only to me and messages are safe from others access and view and I will keep practice updated of my details or changes in consent

Patient Name: _____ Signature: _(type in)_____

Date: ____ / ____ / ____

VACCINATION HISTORY: _____

Family History

	Father	Mother	Father's Parents	Mother's Parents	Sibling	Children
Bleeding Disorder	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Epilepsy/Convulsions	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Other						

Habit Check

Coffee _____ cups/day Alcohol _____ drinks/day or week

Cigarettes _____ no/day Physical Activity _____

Nutrition Issues _____

Drug Allergies

Medication _____ Reaction_____ Mild/ Moderate/ Severe

Medication _____ Reaction_____ Mild/ Moderate/ Severe

Medication _____ Reaction_____ Mild/ Moderate/ Severe

List all medications, vitamins, herbs, creams, potions, lotions you are taking/using

Current Health Problems

Past Health Problems